{York Stenographic Services, Inc.}

RPTS J. BROWN

HIF338.140

``MEDICARE ADVANTAGE: WHAT BENEFICIARIES SHOULD EXPECT UNDER THE PRESIDENT'S HEALTH CARE PLAN''

WEDNESDAY, DECEMBER 4, 2013

House of Representatives,

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Joe Pitts [Chairman of the Subcommittee] presiding.

Present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio),

Pallone, Dingell, Engel, Schakowsky, Matheson, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Sean Bonyun, Communications Director; Noelle Clemente, Press Secretary; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Phil Barnett, Democratic Staff Director; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Committee Staff Director for Health; and Rachel Sher, Democratic Senior Counsel.

|

Mr. {Pitts.} The subcommittee will come to order. The chair will recognize himself for an opening statement.

The Medicare Advantage--MA--program, an alternative to the original Medicare fee-for-service--FFS--program, provides health care coverage to Medicare beneficiaries through private health plans offered by organizations under contract with the Centers for Medicare and Medicaid Services--CMS. MA plans may offer additional benefits not provided under Medicare FFS, such as reduced cost sharing, or vision and dental coverage. They also generally have a high rate of satisfaction, and approximately 28 percent of Medicare beneficiaries have chosen to participate in Medicare Advantage.

The Affordable Care Act--ACA--as noted in a July 24, 2012, Congressional Budget Office--CBO--report, cut $716 billion from Medicare, including $308 billion from Medicare Advantage alone.

In April of 2010, the Medicare Actuary projected that these payment cuts would result in an enrollment decrease in the MA program of as much as 50 percent.

The ACA also required CMS, effective January 1, 2012, to provide quality bonus payments to MA plans that achieve four, four and half, and five stars on a five-star quality rating system developed by CMS. Rather than implement the bonus structure laid out in the law, which would have led to these cuts going into effect in 2012, CMS announced in November 2010 that it would conduct a nationwide demonstration--the MA Quality Bonus Payment Demonstration--from 2012 through 2014 to test an alternative method for calculating and awarding bonuses.

The General Accountability Office--the GAO--in response to a request by Senator Orrin Hatch, noted that the demonstration project's design made ``it unlikely that the demonstration will produce meaningful results'' and recommended that HHS cancel the demonstration. GAO also stated: ``We remain concerned about the agency's legal authority to undertake the demonstration.''

With a price tag of $8.35 billion over 10 years, the Medicare Actuary noted that this demonstration would offset more than one-third of the reduction in MA payments projected to occur under ACA from 2012 to 2014, effectively masking the

first wave of ACA-mandated cuts until next year.

A recent report by the Kaiser Family Foundation warned that more than half a million beneficiaries may have to switch to another MA plan or return to fee-for-service Medicare in 2014 as a result of the ACA.

In addition to plan availability, questions are now being raised about the possibility of rising costs and limited provider networks in the future as more ACA-mandated cuts go into effect.

I would like to thank our witnesses for being here today, and I look forward to their testimony regarding how the ACA will impact the Medicare Advantage program.

[The prepared statement of Mr. Pitts follows:]

********** COMMITTEE INSERT **********

|

Mr. {Pitts.} Thank you, and I yield the remainder of my time to Representative Burgess.

Dr. {Burgess.} I thank the chairman for the recognition. I always want to thank the chairman for calling the hearing this morning.

You know, we see the headlines and we see everything that is going wrong in health care, but sometimes we forget that there are some things that actually are going okay and there are things that this committee and previous Congresses have worked on to fix, and that is one of the things we are going to be discussing this morning, but sometimes we are so busy triaging, we don't allow ourselves the luxury of examining those things that are actually working as intended.

In my opinion, Medicare Advantage is working, and it is important to hold hearings like this to learn from those successes and see where we can build upon those successes and where the potential threats that are undermining the benefits and services that now over 25 percent of seniors are experiencing and how those maybe threatened.

Medicare Advantage allows integrated care coordination

that this committee has sought to bring into fee-for-service Medicare. Medicaid Advantage plans in Texas are lowering costs. They are bringing greater disease management and care coordination to patients' lives. They are encouraging wellness activities and actually using physicians to the maximum ability of their license rather than always referring to a specialist. There are those conditions that can be satisfactorily managed by a general internist or family practice physician, and we ought to encourage that and not punish it. But as money is taking out of the system and plans have been forced to restrain networks and eliminate services that made them such a good deal for seniors, we have to keep a watchful eye.

We are all hearing about people wanting to be able to keep their doctors. Well, the cuts in the Affordable Care Act pose a real danger to seniors keeping their doctors and the benefits that they now have in Medicare Advantage. The harm of these cuts is compounded when the money is not reinvested in the Medicare program. We have heard that before. You can't doubly count the money that you take out of Medicare and then count that again as a savings when you

are not reinvesting the money in Part A or Part B.

One small change that has been bipartisan, Mr. Gonzalez, who used to be part of this committee, when he was on the committee offered a bill that would allow seniors to switch plans between MA plans in the first three months of the year right after the open enrollment period. That was a reasonable suggestion of his at the time, and one that I think the Committee could support.

Mr. Chairman, I had some time to go through the archives, and I encountered a very brilliant and insightful opinion piece that was printed in the Washington Times June 16, 2012, and I would like to offer it for the record.

[The prepared statement of Dr. Burgess follows:]

********** COMMITTEE INSERT **********

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT **********

|

Mr. {Pitts.} The gentleman yields back, and now the chair recognizes the ranking member of the Health Subcommittee, Mr. Pallone, 5 minutes for an opening statement.

Mr. {Pallone.} Thank you, Chairman Pitts, and thank you to our witnesses for being here to share your expertise.

Today I am pleased we have the opportunity to talk about Medicare and the positive reforms introduced by the Affordable Care Act to Medicare Advantage. While the majority of Medicare's 52 million beneficiaries are in the traditional federally administered Medicare program, Medicare Advantage, or MA, offers beneficiaries an alternative option to receive their Medicare benefits through private health plans. Fifteen million people, or 29 percent of all Medicare beneficiaries, are enrolled in MA plans as of September 2013, an increase of 30 percent since 2010.

The ACA included reforms to Medicare Advantage payment policies and added a number of benefits and protections for beneficiaries both through MA and traditional Medicare. For example, Medicare must cover wellness visits and preventative

services with no copayments or coinsurance. The ACA also ensures that MA plans beginning in 2014 spend at least 85 cents of every dollar received in premiums on actual care. Beneficiaries will also receive discounts through the ACA on their medications when they reach the coverage gap, or donut hole, in Medicare Part D, and these discounts will grow over the next several years until the gap is closed.

In addition, the ACA aims to improve the quality of MA plans by rewarding plans that deliver high-quality care with bonus payments. Incentivizing quality patient care over quantity of services provided is key to improving health care outcomes and reducing waste and the rising cost of health care.

The ACA will also bring MA payments more in line with traditional Medicare payments. On average, Medicare has been paying more per enrollee to these private MA plans than the cost of care for those on traditional Medicare. By reducing MA payments over time, there will be greater parity between MA and traditional Medicare payments, resulting in savings that will benefit enrollees and help secure the solvency of the Medicare Trust Fund for a longer period of time.

Now, critics of these payments reforms predicted that MA costs to enrollees would rise, that the provider networks and plan choices would decrease, and MA enrollment would drop. Changes in provider participation, pricing and coverage occur every year as an inherent part of insurers' business decision-making including long before the passage of the ACA, and that is why we have provided tools to CMS to ensure that seniors are protected from potential changes that private plans may make.

In addition, seniors continue to have the choice that best suits their individual health needs, and every year continue to maintain the ability to pick a new plan or traditional Medicare.

So I look forward to hearing more from our witnesses on recent trends in Medicare Advantage. I think we can all agree that our work as a committee needs to continue beyond the improvements we made in the ACA. So your guidance today on ways we can continue to strengthen the program for our seniors is critical. We can't return to the ways before the Affordable Care Act. We must move our health care system to one of quality and efficiency in all of Medicare.

So thank you again, Mr. Chairman, and I yield back the balance of my time.

[The prepared statement of Mr. Pallone follows:]

********** COMMITTEE INSERT **********

|

Mr. {Pitts.} The chair thanks the gentleman, and now recognizes the chairman of the full committee, Mr. Upton, 5 minutes for an opening statement.

The {Chairman.} Well, thank you, Mr. Chairman.

You know, every day we are hearing from folks and families across the country about how the President's health care bill has wreaked havoc on their own health care coverage, with millions receiving cancellation notices, millions more facing premium rate shock, and others still left to wonder if their applications on HealthCare.gov were even successful.

This morning, we are going to focus on how the health care of our Nation's seniors and disabled could be affected by the changes by in the President's health care plan.

The President's health care law cut over $700 billion from the already struggling Medicare program to help fund the flawed new entitlement. Included in these cuts were over $300 billion in direct and indirect reductions to the Medicare Advantage program, and many of these cuts will start in 2014.

Medicare's managed care program, also known as Medicare Advantage, currently provides coverage for more than 14 million Americans, over a quarter of all Medicare beneficiaries, and these patients choose Medicare Advantage plans over traditional Medicare for a variety of reasons including improved cost sharing, enhanced benefits, better care coordination, and in fact, higher quality of care. For millions of Americans, especially those with lower incomes, Medicare Advantage is a better option for delivering their care, and frankly, their choice.

While Medicare Advantage continues to grow, the cuts made in the health care law threaten the future of the program and could put coverage at risk for thousands of beneficiaries in 2014 and many more in the future.

According to a report by the Kaiser Family Foundation, more than half a million beneficiaries may lose their existing Medicare Advantage plan next year, which would then force those seniors and disabled Americans to switch their current plan or return to a traditional fee-for-service plan. More than 100,000 beneficiaries enrolled in a Medicare Advantage plan in 2013 will not be able to enroll in a

Medicare Advantage plan at all in 2014.

Likewise, for thousands of America's most vulnerable, ``if you like your doctor, you will be able to keep your doctor'' is sadly another broken promise. Reports confirm that many Medicare Advantage enrollees will see a change in their provider networks next year as a result of the new law. So empty promises may be of little concern for some but they have real consequences for the Americans who expect us to do no harm. Americans deserve to know why their existing coverage is changing when they were promised otherwise, and this morning's hearing will be an important opportunity to get some answers from a number of good experts, and we appreciate you being here, and I yield to Dr. Cassidy.

[The prepared statement of Mr. Upton follows:]

********** COMMITTEE INSERT **********

|

Dr. {Cassidy.} Thank you, Mr. Chairman.

Over 37,000 of my constituents in Louisiana are enrolled in Medicare Advantage programs. MA plans offer higher quality care and additional benefits, more so than offered in traditional Medicare, and yet despite MA's popularity, MA has challenges.

The President's health care law cuts Medicare Advantage by over $200 billion. Now, I am a doc. When I see that the people who would come to me are having this many cuts in the programs that cover them, intuitively, common sense tells you that they will have increased problems finding a doctor, they have higher premiums, higher copays, fewer benefits and plan choices. Even now with only 20 percent of these cuts implemented, there are reports of these problems already.

I along with Congressman Barrow and 60 other Members of Congress have signed a letter opposing other cuts to the MA program. I urge my colleagues on the committee to make the same commitment to their constituents who have come to rely upon Medicare Advantage.

With that, I yield--

[The prepared statement of Dr. Cassidy follows:]

********** COMMITTEE INSERT **********

|

Mr. {Shimkus.} Dr. Cassidy, will you yield me back the balance?

Dr. {Cassidy.} I yield my time back to the chairman.

The {Chairman.} Yield to Mr. Shimkus.

Dr. {Gingrey.} Mr. Chairman, did you yield to me?

I thank the chairman for yielding.

Look, Medicare Advantage has been around since, what, the late 1980s? It was Medicare Plus Choice, then it was Medicare Advantage, but word ``advantage'' just means exactly what it says. It is an advantage.

You know, it is kind of interesting that the Democrats in creating his Affordable Care Act demanded that policies have minimum coverage requirements, and that this why the cost of so many of those policies has gone up and people have been notified that they are not going to be able to keep those policies January 1, 2014, because they are demanded to include so many additional things. Well, why would Medicare Advantage not cost more because they are more things in it, more provisions, preventive care, annual physical examinations, a nurse checking up, making sure that the

patient got the medications filled, that they return for their appointment and timely follow up? So to gut that program--and that is what this is all about.

I am really looking forward to what the witnesses have to say about it but it made no sense to cut $300 billion out of a program that 29 percent of Medicare beneficiaries had chosen, and it has gone up over the years each and every year, and I yield back.

[The prepared statement of Dr. Gingrey follows:]

********** COMMITTEE INSERT **********

|

Mr. {Pitts.} The gentleman's time has expired. The chair now recognize the ranking member emeritus, Mr. Dingell, 5 minutes for opening statement.

Mr. {Dingell.} I don't have an opening statement. I am going to have some fun with my questions. Thank you, Mr. Chairman.

[The prepared statement of Mr. Dingell follows:]

********** COMMITTEE INSERT **********

|

Mr. {Pitts.} The opening statements have been made by the members. I will now introduce our panel of five witnesses.

The first is Mr. Douglas Holtz-Eakin, President, the American Action Forum; Mr. Joe Baker, President, Medicare Rights Center; Dr. Bob Margolis, CEO, HealthCare Partners, and Co-Chairman of DaVita HealthCare Partners; Ms. Marsha Gold, Senior Fellow, Mathematica Policy Research; and Mr. Jon Kaplan, Senior Partner and Managing Director of the Boston Consulting Group.

Your written testimony will be made part of the record. You will have 5 minutes to summarize your testimony, and at this time, the chair recognizes Mr. Holtz-Eakin for 5 minutes for opening statement.

|

^STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM; JOE BAKER, PRESIDENT, MEDICARE RIGHTS CENTER; ROBERT J. MARGOLIS, M.D., CEO, HEALTHCARE PARTNERS, AND CO-CHAIRMAN, DAVITA HEALTHCARE PARTNERS; MARSHA GOLD, SENIOR FELLOW, MATHEMATICA POLICY RESEARCH; AND JON KAPLAN, SENIOR PARTNER AND MANAGING DIRECTOR, BOSTON CONSULTING GROUP

|

^STATEMENT OF DOUGLAS HOLTZ-EAKIN

} Mr. {Holtz-Eakin.} Thank you, Chairman Pitts, Ranking Member Pallone and members of the committee for the privilege of appearing today.

Let me take this opportunity to emphasize a few points that I made in my written statement.

The first, as has been pointed out by the chairman and others in their opening statements, is that Medicare Advantage is a valuable and popular part of Medicare with nearly 30 percent of beneficiaries voluntarily enrolled in it, increasing enrollments each year, and it does provide extra services and innovative approaches to health care in

the Medicare program. It disproportionately serves lower-income beneficiaries and minorities, and has been the program of choice for them, but most importantly, Medicare Advantage is not fee-for-service medicine and thus it represents an important opportunity to move away from the practice of medicine that has proven costly and that rewards volume over quality in the American health care system.

Unfortunately, Medicare Advantage is under a four-fold funding reduction due to provisions in the Affordable Care Act and then others more recently. The first stems from reductions in fee-for-service spending per se; the second, the modification of the Medicare Advantage bench marks relative to fee-for-service spending in each county; the third, the implications of a health insurance tax that will come online in 2014, which will affect many MA plans and further act as a pressure on the ability to provide benefits; and the fourth, the recent requirement that CMS provide changes in the coding intensity for Medicare Advantage plans.

The results of these changes are inevitable. The first will be fewer plans. Estimates range from 60 to 140 fewer plans in 2014. There are reports of 10,000 cancellation

notices in Ohio, 50,000 in the State of New Jersey, and these all represent further violations of the pledge that if you like your health insurance, you can keep it under the Affordable Care Act.

In addition, there will be fewer enrollees. Projections are that there will be up to 5 million fewer enrollments by 2019 when the ACA cuts are fully implemented, and these reductions are disproportionately borne by lower-income Americans. Our estimates are that about 75 percent of the impacts hit those making less than $34,200.

The next step for those plans that do survive is to pass along these reductions in the form of either higher cost sharing or reduced benefits or more limited networks that provide beneficiaries with fewer choices. These are not the voluntary decisions of insurers; these are the natural consequences of the law which limits their ability to provide options to beneficiaries.

Going forward, I would emphasize that it is very important to preserve this steppingstone to coordinated care and the better practice of medicine in Medicare and that it would be extremely undesirable for Congress to repeat the

practice of using Medicare Advantage as a funding source for further expansions of other program initiatives. This is a valuable program that has proven on the ground to provide high-quality care, innovative approaches to medicine, and is the popular choice of many of the least well-off beneficiaries. Further reductions in its availability are an undesirable policy step.

I thank you, and I look forward to answering your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

********** INSERT A **********

|

Mr. {Pitts.} The chair thanks the gentleman and now recognizes Mr. Baker 5 minutes for summary of his opening statement.

|

^STATEMENT OF JOE BAKER

} Mr. {Baker.} Thank you, Chairman Pitts and Ranking Member Pallone and distinguished members of the subcommittee.

Medicare Rights is a national nonprofit organization that works to ensure access to affordable care for older adults and people with disabilities, and we thank you for this opportunity to testify on the Medicare Advantage program.

Each year we counsel thousands of people with Medicare Advantage about topics ranging from enrolling in a plan to appealing a denied claim. We find that Medicare Advantage plans are a good option for some but not all people with Medicare. Many of our callers are satisfied with their plan and their inquiries are easily resolved. Others find navigating a Medicare Advantage plan challenging. These callers may struggle to resolve billing issues, cope with coverage denials, compare plan details and other issues.

In particular, we observe that people find choosing among Medicare Advantage plans sometimes a dizzying

experience. We urge people every year to revisit their plan's coverage as annual changes to plan benefits, cost sharing, provider networks and other coverage rules are commonplace each year. Yet research suggests that inertia is widespread. Put simply, there are too many plans, too many variables to compare and too few meaningful choices among plans.

The Affordable Care Act offers a blueprint for constructing a high-value health care system where insurance plans, physicians, hospitals and other providers are paid according to the quality of care that they provide. Medicare is the incubator for many of these reforms. As such, the ACA includes a set of policies designed to make the Medicare Advantage system more efficient and to enhance plan quality. Alongside physicians, hospitals and other health care providers, Medicare Advantage plans have been and should be playing an important role in this transformation.

Medicare Advantage provisions included in the ACA are ultimately intended to secure higher-volume care; in other words, better quality at a lower price. Recent changes to MA by the ACA have strengthened the program. In addition to

improving Medicare's overall financial outlook, the ACA enhanced Medicare Advantage through added benefits, fairer cost sharing and improved plan quality. For instance, the ACA expands coverage for preventive services, prohibits Medicare Advantage plans from charging higher cost sharing than original Medicare for renal dialysis, chemotherapy and skilled nursing facility stays and requires that plans spend 85 percent of beneficiary premiums and federal payments on patient care. These and other changes that the ACA has brought to Medicare Advantage should be preserved.

It is important to note that ACA savings secured largely from Medicare Advantage payment adjustments are producing positive returns for the Medicare program benefiting both current and future beneficiaries. Improving cost efficiency in Medicare translates into real progress for older adults and people with Medicare and people with disability. For example, in 2014, the Part B premium remains at its 2013 level, amounting to $104.90 per month.

While many predicted that ACA changes to Medicare Advantage would lead to widespread disruption of the plan landscape, we have not seen that among our clients that we

serve generally. The premiums, benefit levels and availability of plans remain relatively stable. In fact, the Medicare Advantage market is now better and more robust for consumers, and enrollment continues to be on the rise in this year.

While there appears to be an increased incidence of slimming of Medicare Advantage provider networks this year, we must stress that we see this every year. Changing provider networks are an inherent risk of any managed care system. Our advice to Medicare beneficiaries remains the same: people can switch to another Medicare Advantage plan or back to original Medicare or traditional Medicare during the fall open enrollment period, which is occurring right now, in any situation where a current Medicare Advantage plan does not meet their needs.

In closing, we believe that Congress should do more to simplify plan selection and coverage rules for people with Medicare Advantage. We recommend improving beneficiary notice regarding annual plan changes including changes in plan networks and further streamlining and standardizing plans, improving the appeals system, and adequately funding

independent counseling resources like the SHIP program. We also urge Congress to expand the range of supplemental coverage options available to people with original Medicare for those cases where a Medicare Advantage plan is not the best fit for beneficiaries' needs and also to allow people to go back and forth between the Medicare Advantage plan and the original Medicare program with more facility.

We really thank you for the opportunity to testify today.

[The prepared statement of Mr. Baker follows:]

********** INSERT B **********

|

Mr. {Pitts.} The chair thanks the gentleman and now recognizes Dr. Margolis 5 minutes for summary of his opening statement.

|

^STATEMENT OF ROBERT MARGOLIS

} Dr. {Margolis.} Thank you, Chairman Pitts and Ranking Member Pallone and esteemed committee members for the invitation to address you today. I come to address the merits of Medicare Advantage, having had many years of experience in the program, and can tell you without any hesitation, it is the most effective federal program moving seniors to higher-quality care through coordination and measurement of quality and outcomes.

I come wearing multiple hats as my 40 years in health care and health care policy has taken me in many directions: the California Association of Physician Groups, which I chaired and which represents over 90 percent of all coordinated care patients in California, my board representation and chairmanship at NCQA, which has proven through extensive measurement and transparency that the quality and measurement that occurs in Medicare Advantage is superior to the fee-for-service original alternative; as you mentioned, my role as CEO of HCP, HealthCare Partners, but

mostly as a doctor at a practice for over 20 years in an urban inner-city hospital in Los Angeles serving primarily seniors and other disadvantaged patients where I saw that without equivocation, the fee-for-service mentality of the original Medicare, or as we like to refer to it, fee for volume, is not coordinating care for seniors.

Seniors who have multiple chronic diseases, who are vulnerable and especially those that are poor and with less than fewer resources, need an ideal system, a system that helps with great information and a physician advisor to help them navigate through a very difficult and complex health care system and manage them longitudinally across time. As a physician, I can tell you that every physician I know manages his or her patients with great desire to do the best outcome but does not have the infrastructure, the coordination and the resources to follow that patient longitudinally through their health care needs, and that is the one major advantage of coordinated care, population health, managed care, however you choose to name it. Population health, for those that perhaps are unfamiliar with that term, really is having patients select a doctor through a network, through a health

plan, and then having that physician organization take responsibility through a per-member per-month or capitation for the total are of that patient. It totally changes the incentives, and incentives drive behaviors. The behaviors within a coordinated care program are one of health promotion, defer and delay chronic disease through much more intervention, disease management, pharmacy management, making sure that patients get to their specialist, get to their visits, have home care programs.

So let me explain a little bit about how that works within our organization, which is relatively large. We care for now over 250,000 Medicare Advantage patients through our 11,000 affiliated and employed physicians in five different States, and the way that works is through great information technology, which is a big investment but an important investment that allows us now to segment the patient population into areas of need and design programs specifically to those areas of need. So for instance, there are home care programs for those most vulnerable that have trouble getting into the doctor's office and avoids 911 calls and trips to the emergency room. There are comprehensive

care clinics for those folks that have very complex diseases where there is individual care plans monitored by a team, and I have to say without equivocation, health care best delivered is a team sport. It is great to have a physician in the center of that team, but having care managers, having disease management, having social workers, having dieticians, having home care capabilities is a key component of making it an effective system, so I ask you without any equivocation, please continue to support MA, strengthen it, help it grow, support special needs program, support moving the duals into Medicare Advantage in a coordinated way with the States. It is a very vulnerable population that could use Congress's support with CMS to make that effective.

And with that, I will yield the last 6 seconds back to you.

[The prepared statement of Dr. Margolis follows:]

********** INSERT C **********

|

Mr. {Pitts.} The chair thanks the gentleman, and now recognizes Ms. Gold 5 minutes for summary of her opening statement.

|

^STATEMENT OF MARSHA GOLD

} Ms. {Gold.} Hello. Thank you, Chairman Pitts, Ranking Member Pallone and members of the subcommittee to talk to you about Medicare Advantage.

As a Senior Fellow at Mathematica for the past 20-plus years, I have been examining Medicare Advantage for a long time, analyzing trends and plan participation, enrollment and benefits, looking at market dynamics and studying the implications for beneficiaries, working with the Kaiser Family Foundation and others.

My testimony today makes three points that I hope will inform the Congressional debate on the Medicare Advantage program today. My independent findings, I should day, in general are closely aligned with the positions and opinions expressed by MedPAC.

First and foremost, and we have heard this in a few other places here today, the MA program is strong with rising enrollment and widespread plan availability that is expected to continue through 2014, despite the concerns that the

cutbacks in payment would discourage plan participation or make plans less attractive. There is 15 million people in the program, 29 percent of all benefits an all-time high, although it varies a lot across the country, and I think it is important to recognize that health care is local and the circumstances are different. The kind of care Dr. Margolis mentions happens in some places and not others.

Second, despite concerns over plan terminations in 2014, there are almost as many new plans entering in 2014 as terminating, and since the ACA was enacted, average in premiums to enrollees have declined, and they will still be lower in 2014 than they were in 2010. Exit and entry are essential characteristics of a competitive market. Medicare beneficiaries today have an average of 18 Medicare Advantage choices as well as the option to stay in the traditional Medicare program and with or without a supplement. Medicare beneficiaries can keep their plan. It is called Medicare, whether you are in Medicare Advantage or Medicare traditional.

It is difficult to see the rationale on a national basis for paying private plans more than Medicare currently spends

on the traditional program, particularly when there is so much concern with the deficit and debt. Medicare has historically aimed to set payments to MA plans below or equal to what Medicare would expect to pay in the traditional program for beneficiaries who enroll in the plans. This changed in 2003, and by 2009, payments were considerably higher than Medicare would have paid for the same beneficiaries if they were in the traditional program. This costs every beneficiary more in added Part B premiums and it provides little incentive for MA plans to become more efficient. When I examined the 2009 plan bid data, I found wide variation in MA plans' costs relative to traditional Medicare spending, even controlling for plan types and payment levels. That suggests there was room for a lot more efficiency in the program variable across plans, and the policy changes that were in the ACA reflect recommendations that Congress's own Medicare Payment Advisory Commission has advocated for years.

Third, many of the concerns raised about 2014 offerings from what I have looked at are not consistent with evidence or inherent part of the way competitive markets work, and

they are already addressed by protections in place in the program. Only 5 percent of enrollees in 2013 will have to shift plans. Most will be able to stay in the same type of plan. The average premium was down 21 percent from between 2010 and 2013 for a beneficiary, and premiums were stable in 2014. Some beneficiaries will see their premiums rise in 2014 but they will still be paying less than 2010, and if historical patterns hold, some of the beneficiaries will switch around so that they can get a better deal.

Clearly, payment reductions can discourage plans from participating in Medicare Advantage but this doesn't yet appear to be an issue, and Medicare has a number of protections for this such as network adequacy and quality standards, required notice of change in plans and provider networks and other means. Because MA choice is voluntary, there is also the option to return to traditional Medicare.

In its March 2013 report to Congress, MedPAC concluded that the payment changes under the Affordable Care Act have improved the efficiency of the program and may have encouraged plans to respond by enhancing quality, all the while continuing to increase MA enrollment through plans and

benefit packages that beneficiaries find attractive. I believe my analysis and testimony is consistent with MedPAC's conclusion.

Thank you for your time, and I look forward to any questions.

[The prepared statement of Ms. Gold follows:]

********** INSERT D **********

|

Mr. {Pitts.} The chair thanks the gentlelady and now recognizes Mr. Kaplan 5 minutes for summary of his opening statement.

|

^STATEMENT OF JON KAPLAN

} Mr. {Kaplan.} Chairman Pitts, Ranking Member Pallone and members of the subcommittee, thank you for the opportunity to testify today.

My name is Jon Kaplan, and I am a Senior Partner of the Boston Consulting Group. I have a health care background that is over 25 years, working closely with both nonprofit and for-profit health care entities throughout the entire health care industry.

Earlier this year, I led a BCG team that analyzed the differences in health outcomes between patients enrolled in traditional Medicare and those enrolled in private Medicare Advantage health plans. We found that patients enrolled in the Medicare Advantage plans had better health outcomes than those participating in traditional Medicare.

There are three key findings from our research. First, the MA patients in our sample received higher levels of recommended preventive care and had fewer disease-specific complications. Second, during acute episodes requiring

hospitalization, the patients in the MA plans spent almost 20 percent less time in the hospital than those in traditional Medicare. In addition, they had less readmissions into the hospital. Finally, the percentage of people who died in the year we studied was substantially higher in the traditional Medicare sample than those in the Medicare Advantage sample. This is a striking finding and one that we hope to explore further in a longitudinal, multiyear study.

Our study did not directly address the causes of these differences. In my experience, however, the key factor is MA itself and how the plans are organized and managed. First, these plans align financial incentives with clinical best practice. Second, they recruit the most effective providers and include only those who practice high-quality medicine. Third, they put a strong emphasis on active care management and invest resources in prevention to keep patients healthy, stable and out of the hospital.

There are many indications in our study that these three mechanisms are responsible for the better health outcomes of the MA patients. Take the example of diabetes. Two clinical standards for diabetes care are frequent HbA1c testing and

regular screenings for kidney disease. Our data show that the MA sample had substantially higher number on both tests than in the traditional Medicare sample. This stronger focus on prevention helps keep patients healthy and avoids the need for highly disruptive and expensive acute care interventions. For example, we found that diabetic patients in MA had dramatically fewer foot ulcers and amputations than those patients in traditional Medicare.

Aligned incentives and active care management also helps explain lower utilization rates. Take the example of emergency room visits. In our traditional Medicare matched sample, about four out of ten of the patients visited the emergency room at least once per year. For many portions of Medicare Advantage, however, this figure drops to around two out of ten.

One last finding to share: Among the three types of MA plans that we studied, the very best health outcomes were for those patients in the capitated MA plan. The findings suggest that capitation is extremely effective at supporting provider investment and preventive medicine and active care coordination.

Let me conclude bys suggesting some implications of our study for health policy. In my opinion, Medicare Advantage plans are an example of a successful public-private partnership. These plans represent an integrated care delivery model that uses effective provider incentives, real-time clinical information and care coordination capabilities to improve quality and lower cost. In my opinion, federal policy should be supporting and not discouraging more Medicare patients to enroll in MA. Their health outcomes and the entire U.S. health care system are likely to be better as a result.

Thank you for inviting me to speak, and I look forward to answering your questions.

[The prepared statement of Mr. Kaplan follows:]

********** INSERT E **********

|

Mr. {Pitts.} The chair thanks the gentleman. That concludes the summaries.

Before we go to questioning, I'd like to seek unanimous consent to submit for the record a letter from the 60 Plus organization. Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT **********

|

Mr. {Pitts.} I will now begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. Holtz-Eakin, since passage of the President's health care plan, millions of Americans and their families have received insurance cancellation notices. Do you think Medicare Advantage may be Obamacare's next victim, and if so, what might beneficiaries in Pennsylvania expect over the coming years in terms of plan choices, cost, foregone benefit offerings and provider networks?

Mr. {Holtz-Eakin.} Thank you, Mr. Chairman. Indeed, I am concerned about the future of Medicare Advantage, as I said in my opening statement. The work we have done on the implications of ACA cuts, for example, in Pennsylvania, would suggest that in 2014, there would be an average loss of benefits per beneficiary of about $2,200, that this is about a 19 percent reduction in those benefits, and that we would see a decline in the activity of Medicare Advantage to about 113,000 Pennsylvanians, and those numbers for 2014 are of concern but I am more troubled by the trajectory over the succeeding 5 years and the full cuts under the Affordable

Care Act as to whether Medicare Advantage will remain a viable option within the Medicare program and deliver the comprehensive benefits.

And I just want to echo the statements that we heard in many of the opening remarks. The Medicare population is so different than when Medicare was originated. It is now a population that has multiple chronic conditions and comorbidities. It requires a coordinated approach to care. That is the route to both better health and financial future for Medicare as a whole. Medicare Advantage, I think, is an important steppingstone to that future.

Mr. {Pitts.} Thank you.

Dr. Margolis, as you know, this committee has been committed in a bipartisan form to address access concerns in part by improving the flawed physician patient formula for participating Medicare doctors. However, I believe Medicare Advantage plays a key role in ensuring the physician-patient relationship for seniors and the disabled. What impact, in your opinion, will the permanent solution to the flawed SGR formula have on the viability of the Medicare Advantage program?

Dr. {Margolis.} Thank you, Mr. Pitts. There is no question that the cuts that are proposed and coming down on Medicare Advantage, and I would specifically stress the rescaling of the risk adjustment factor, which really was a key component in what I believe is making it a positive incentive to care for the sick and fragile patient was to be paid based on the acuity of the patient, and so the potential of reducing significantly the payments relative to the most expensive patients starts to flip back to that possibility that the people will not be able to gain care if they are really sick, and that is a potential serious problem.

And I would also like to just say that Medicare Advantage should not, in our opinion, be the pay-for for an SGR fix. I think that as you have heard from all these other witnesses that it is extremely important for the seniors of our country, 10,000 more of which are entering Medicare every day, to be able to access good coordinated care and especially for that 5 percent of patients that are eating up 52 percent of all health care dollars, those sickest and most fragile patients, to be able to access the doctors of their choice and get the care they need.

Mr. {Pitts.} Thank you. Here is a question for the panel. Medicare Advantage has a proven record of success and is popular with seniors because it provides better services, a higher quality of care and increased care coordination. To ensure the program's viability, I believe there are several existing reform proposals for Medicare Advantage that merit further discussion and feedback, concepts like overlaying a value-based insurance design over the existing Medicare Advantage program to address a substantial variation in value across health care services and providers, bipartisan policies such as those introduced by Representative Keith Rothfus of Pennsylvania that would restore choices for Medicare Advantage beneficiaries and not limit their options to traditional FFS or their existing plans, improvement to the program's special needs plans and improvements to the program's risk adjustment framework that would improve accuracy of payments and account for chronic conditions.

What, if any, short-term reforms could we consider that would ensure the viability of the program in promoting maximum value and high-quality coordinated care for Medicare beneficiaries? We will start with you, Mr. Kaplan.

Mr. {Kaplan.} First of all, thank you, Mr. Chairman. The best way I would answer that question is, is that there are a lot of successes that are already in place in Medicare Advantage. I think everybody on the panel today has said that Medicare Advantage is a program to look at with some very positive reactions.

What I think happens fundamentally in the Medicare Advantage program is that it allows for more of a freedom of choice among the different competitors in there being the insurance companies that are offering those programs and allows for the members who choose to go into those programs to navigate themselves around to different programs, to make a choice and to find what best meets their needs. That sort of freedom of choice has allowed for the programs to prosper based on what they offer to the members who sign up for their programs as opposed to mandating things in different ways.

So the competitive model amongst the different insurance companies who are offering different programs in different States, I think that strong model has allowed for the growth of the program to be so successful and effective at practicing the medical care that we all are talking about

that we want to do for the senior population.

Mr. {Pitts.} Thank you. My time is expired. I will give you this question and I will submit it in writing and you can respond for the record.

The chair now recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. {Pallone.} Thank you, Mr. Chairman.

I am going to ask my questions of Mr. Baker because you seem to be able to clear up a lot of the myths that I am hearing from the Republican side.

As you heard, opponents of the ACA say that the Medicare Advantage program will be obsolete because of cuts in the Affordable Care Act. The Republicans basically think the Affordable Care Act is the end of the world. I mean, you understand all that.

Mr. Baker, do you feel that the Medicare Advantage program is stronger now and more secure for beneficiaries than before the Affordable Care Act? If you could just answer that?

Mr. {Baker.} Sure. I think there are a couple components to that. One is that this equalization of

payments between the Medicare Advantage program and the traditional or original Medicare program, I think once again there is an equity there that has been established as well as the fact that Part B premiums have come down or stabilized for everyone in the Medicare program. I think the other piece is that consumers are better protected in Medicare Advantage. Some plans had increased cost sharing for services like chemotherapy, higher cost sharing than is allowed in the traditional Medicare program. The Affordable Care Act has equalized once again cost sharing so that sicker beneficiaries aren't discriminated against--the 85 percent Medical Loss Ratio that is required in Medicare Advantage now, making sure that 85 percent of those premium dollars, both from consumers as well as from the government, are going towards medical costs, not other administrative costs. The star ratings--we now have a rating program where plans have one to five stars based upon their quality and plan performance. This has been an important tool for consumers to choose between plans and also that quality information has been getting out to consumers and I think more can be done in that regard but I think is very good.

The other thing is the out-of-pocket maximums that were introduced over the course of the last few years and have provided important protections for consumers so that these Medicare Advantage protections not only make the program more equal, if you will, between the traditional or original Medicare program but also ensure that consumers are better protected with consumer rights and consumer protections once they are in the plan.

Mr. {Pallone.} So obviously you feel that Medicare Advantage is stronger now and more secure because of the ACA?

Mr. {Baker.} Yes, I do, and I think consumers are better protected within the Medicare Advantage program because of the ACA.

Mr. {Pallone.} Do you think that the changes pursuant to the ACA give beneficiaries more confidence in the program, might even make them more comfortable in choosing a Medicare Advantage plan?

Mr. {Baker.} I think it does. I think the ACA with the star ratings program, with other quality initiatives in the Medicare Advantage plan have made consumers more confident. We find that folks are looking at these star ratings or

looking at these other quality metrics that are now available under the ACA. I think they also are--many of the consumers that we talk to appreciate that they have a choice between Medicare Advantage and original Medicare. So I think it is also important that the original Medicare program, which is the base of all of this, be kept strong and be kept as a very viable option for folks that Medicare Advantage either hasn't worked for or it won't work for in the future.

Mr. {Pallone.} All right. And can you tell me how robust the choices are for seniors in the MA program? How many choices do they have?

Mr. {Baker.} Right. I think on average, consumers continue to have about 18 plan choices, and I think Ms. Gold went through some of those metrics in her testimony. We find for the most part, and this is both true in the Medicare Advantage program as well as in the Part D prescription drug program, that consumers are really--the biggest question we have from consumers is, they have too many choices and they are too confused by the variety of plans. So over the last few years, the Centers for Medicare and Medicaid Services has made some headway in tamping down the number of choices that

aren't meaningful. By that, I mean there might be one little tweak to a plan to make it somewhat different than another plan that a company is offering and, you know, folks get confused by those tweaks that don't have a real substantive component to them. And so narrowing choices in that way has helped people actually make better choices.

Mr. {Pallone.} And you don't feel that--I mean, again, you don't buy the naysayers who say that the ACA is going to narrow choices for seniors in the MA program?

Mr. {Baker.} It has not at this point, not substantively. We see plenty of plan choices out there in the markets where we are seeing clients. Once again, our problem in counseling most of our consumers, really all of our consumers, isn't that they don't have a choice, it is that they have too many choices of Medicare Advantage plans before passage of the ACA and after passage of the ACA.

Mr. {Pallone.} Thank you very much.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the vice chairman of the full committee, Ms. Blackburn, 5 minutes for questions.

Mrs. {Blackburn.} Thank you, Mr. Chairman, and thank

you all for being here.

Dr. Margolis, I want to come to you. You talked a bit about the fragile and vulnerable populations, and I want to go back to that--end-stage renal disease. I recently found out that those Medicare Advantage enrollees that have end-stage renal disease have access to a coordination of care that is not available to others. It is not an option for those that are in standard Medicare. So why should Medicare Advantage not be an option for all Medicare enrollees?

Dr. {Margolis.} Thank you, Mrs. Blackburn. I support that. I believe that coordination of care is ideal for sick and fragile patients especially. ESRD, I know they are pilots now at CMS to try to incorporate population health for ESRD. I would encourage them to be strengthened. I think it is an artifact of the way the law was originally written that ESRD patients were not allowed to enroll in Medicare Advantage. That could and should be changed, in my view. The way that works is that if a patient has chronic renal disease and enrolls in Medicare Advantage and becomes an end-stage patient, they can stay in Medicare Advantage, but if they have already been diagnosed as end-stage renal disease,

they are not allowed to enroll in Medicare Advantage.

Mrs. {Blackburn.} It would be an element of fairness into the system that would allow--

Dr. {Margolis.} I believe that would be an improvement, yes, ma'am.

Mrs. {Blackburn.} All right.

Mr. Kaplan, I want to come to you for a minute. I loved listening to your testimony today. I have to tell you, in my district, seniors love their Medicare Advantage. We have got a program called Silver Sneakers in our district, and people come to town hall meetings, they talk to me about Silver Sneakers and how they are doing, and I have looked at some of the work that they have done and the surveys, better outcomes for physical and emotional health, more activity. It has just been a great program.

So as I have listened to you all today, talk to me for a minute. We talk about stabilizing Medicare, giving seniors more choices, giving them more options. Should Medicare Advantage not be the platform for Medicare reforms and give seniors more choice and options, not less?

Mr. {Kaplan.} Well, first of all, thank you for the

nice comments.

I am a huge fan of Medicare Advantage for exactly the reasons you say. It aligns the incentives so that the providers and the payers work together to try to figure out what is the best way to take care of their members and their patients, and when they align the incentives, they start to work on things, and they say one of the most important things is to coordinate care, as Dr. Margolis talked about, which is, let us coordinate the care for especially these complex members and so forth, let us find things that can help them to prevent having the diseases either progress or even begin. All these things are aligned. All these things are the idea of aligning incentives, coordinating care, and it is all for the benefit of the member. And so therefore I do believe, as you said, that Medicare Advantage is a wonderful pilot for us as a society, because what it does is, it shows that we can find a way to curb the growth of health care costs, we can find a way to improve--

Mrs. {Blackburn.} So curb the cost, give greater access and provide better outcomes?

Mr. {Kaplan.} Correct.

Mrs. {Blackburn.} Mr. Holtz-Eakin, do you want to weigh in?

Mr. {Holtz-Eakin.} I would just echo the fairness issue, which I think is important, and we know that Medicare as a whole is facing a very, very problematic financial future. If we can find ways to control those costs and provide better care, we should, and this is a route to that.

Mrs. {Blackburn.} Let me ask you this. When you look at the implementation of the ACA and the cuts that are being made, who is most impacted by the MA cuts that are there? Is it seniors? Is it physicians? Is it the support system for seniors? What in your research do you see? Yes, sir?

Mr. {Holtz-Eakin.} This is impact directly to the seniors whose choices will be restricted, whose benefits will be reduced, and I am deeply concerned about the long implications. I understand the testimony of Mr. Baker about consumer protections and confidence in the program but that is at odds with the fact that the CBO, for example, projects that there will be 5 million fewer enrollees in Medicare Advantage in 2019, if they felt more confident, we got 10,000 new seniors every day, you would expect the number to rise,

not fall, and I think that is stark testimony to the financial underpinnings being not strong enough and then that will limit the benefits and the choices of seniors.

Mrs. {Blackburn.} Yield back.

Mr. {Pitts.} The chair thanks the gentlelady and now recognizes the ranking member emeritus, Mr. Dingell, 5 minutes for questions.

Mr. {Dingell.} Mr. Chairman, I thank you for your courtesy and for your kindness.

This is an important moment, and the American people are counting on us. I am concerned that the committee might be holding another hearing to try to scare people about the Affordable Care Act and its impact on Medicare Advantage when the facts do not support those claims. The questions I have today will focus on how ACA impacts Medicare Advantage as well as traditional Medicare. I would point out that when we adopted the idea of Medicare Advantage, we were told that they were going to give us a lot more insurance and a lot less cost to senior citizens, and I have heard constant whining ever since that we have not done that.

In any event, we have a problem here because that

program is costing taxpayers significantly more than traditional Medicare while providing only similar services.

So Mr. Baker, yes or no, is it correct that in 2009 before passage of ACA, CMS paid Medicare Advantage plans $14 billion more than if the same care had been provided under traditional Medicare? Yes or no.

Mr. {Baker.} Yes.

Mr. {Dingell.} And this averages out to about $1,000 per beneficiary? Yes or no.

Mr. {Baker.} Yes.

Mr. {Dingell.} Now, additionally, Ms. Gold, a 2009 MedPAC report found that Medicare Advantage payment benchmark was 118 percent of what Medicare would spend. Is that correct?

Ms. {Gold.} Yes.

Mr. {Dingell.} Now, Mr. Baker and Ms. Gold, is it fair to say that the reforms made by ACA were intended to align Medicare Advantage payments with traditional Medicare payments? Yes or no.

Ms. {Gold.} Yes.

Mr. {Baker.} Yes.

Mr. {Dingell.} Now, despite claims made by some of my colleagues, these reforms have not ruined Medicare Advantage. In fact, the program is strong and growing. Earnings are doing fine. Salaries, dividends, bonuses and all those other good things to the companies and their officers who are participating are growing.

Now, Mr. Baker, how many people are enrolled in Medicare Advantage today? I believe the number is 15 million. Is that right?

Mr. {Baker.} Correct. Yes.

Mr. {Dingell.} Now, Mr. Baker, is it correct that Medicare Advantage enrollment has increased 30 percent from 2010 to 2013? Yes or no.

Mr. {Baker.} Yes, it is.

Mr. {Dingell.} It seems like they are doing pretty well, doesn't it?

Mr. {Baker.} Yes, it does.

Mr. {Dingell.} Now, Mr. Baker, is it correct that the average Medicare beneficiary will have a choice between 18 plans available to them in 2014? Yes or no.

Mr. {Baker.} Yes, it is.

Mr. {Dingell.} So Mr. Baker and Ms. Gold, the Affordable Care Act has not resulted in a drastic decrease in the number of plans available to seniors who choose to participate in Medicare Advantage nor has it decreased the number of people participating in the program? Is that correct? Yes or no.

Ms. {Gold.} Yes.

Mr. {Baker.} Yes.

Mr. {Dingell.} Thank you. Now, in fact, I note that ACA has provided many benefits to this population and will continue to do so. Most importantly, the ACA has improved the solvency of the entire Medicare program, something which is not properly addressed by people who are critical of ACA.

Now, Mr. Baker, is it correct that Medicare hospital insurance trust fund is now solvent through 2026? That is 10 years longer than prior to the passage of ACA. Yes or no.

Mr. {Baker.} Yes.

Mr. {Dingell.} That tends to show that this was quite helpful to the Medicare trust fund, right?

Mr. {Baker.} Yes, it does.

Mr. {Dingell.} Now, in 2012, 34.1 million Medicare

beneficiaries were able to access preventive services such as mammograms and colonoscopies with limited cost sharing. Is that correct? Yes or no.

Mr. {Baker.} Yes.

Mr. {Dingell.} Now, some 7.9 million seniors have saved over $8.9 billion since the passage of ACA, and that is thanks to the donut hole being closed. Is that right?

Mr. {Baker.} Yes.

Mr. {Dingell.} And the donut hole is going to be closed completely by sometime around 2020. Is that right?

Mr. {Baker.} That is correct, yes.

Mr. {Dingell.} So thank you, gentlemen and ladies. This committee has a great tradition of working together to solve the pressing issues of the day. I hope we can resume this tradition with vigor and focus on the facts rather than continuing to try to scare people about the Affordable Care Act. Let us give it a chance. Let us work together. Let us see that it has a chance to provide the benefits to the society and the practice of medicine and to the sick, ill and ailing in this country that we want to have.

Mr. Chairman, I thank you for your courtesy.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the vice chair of the subcommittee, Dr. Burgess, 5 minutes for questions.

Dr. {Burgess.} Thank you, Mr. Chairman.

Dr. Holtz-Eakin, you were kind of left out of that last exchange. Do you have quick thoughts on the $14 billion excess cost for Medicare Advantage that Chairman Dingell referenced?

Mr. {Holtz-Eakin.} The reimbursements should be aligned with quality, and I think the most important issue is the quality of care that seniors receive under Medicare Advantage as opposed to fee-for-service medicine.

Dr. {Burgess.} Let me switch gears a little bit. You know, the Affordable Care Act, and I was here through the entirety of how it came through the committee and how it came through Congress, and it becoming pretty obvious today that there were some assumptions and some promises that were made in the Affordable Care Act that have now turned out to not be true, and I would submit that those weren't just errors in projections, those were actually active and purposeful deceptions. If the Administration had been honest with

Americans about this bill, it very likely never would have passed.

So the Affordable Care Act does take $716 billion out of the Medicare program. Is that correct?

Mr. {Holtz-Eakin.} That is correct.

Dr. {Burgess.} And the portion that is taken from Medicare Advantage is about $150 billion. Is that correct/

Mr. {Holtz-Eakin.} Yes.

Dr. {Burgess.} So that is taken away from our seniors, the Medicare Advantage plans. I mean, I can remember distinctly speeches given, particularly during the Democratic Convention in 2012, that these are merely overpayments to doctors and hospitals; this is not a real cut. It is just taking away money that shouldn't have been paid in the first place. Do you recall those speeches?

Mr. {Holtz-Eakin.} Not specifically but I remember the claims.

Dr. {Burgess.} So do you agree with the Administration, with the American Association of Retired Persons, Congressional Democrats that these cuts were merely ridding the plans of inefficient payments?

Mr. {Holtz-Eakin.} I don't agree with that. They are part of an historic strategy of provider cuts that has always backfired. The SGR is the leading example. It limits access to seniors in the end. It doesn't take out excess costs. And a continued reliance on this strategy is going to damage Medicare and not save its financial future. We need to change strategies.

Dr. {Burgess.} I agree with you.

You know, there was an article in the paper recently that United Health Care was forced to limit access to some doctors because of reductions in Medicare Advantage. There was an article in USA Today that talks about a story about a patient named Dorothy Sanay that her doctor had some bad news after her last checkup but it wasn't about her diagnosis. Her Medicare Advantage plan from United was terminating her doctor's contract after February 1st, and she also found out she was losing her oncologist at the prestigious Yale Medical Group. She is 71 years old and on Medicare.

So it kind of seems like this is a direct consequence of cutting the Medicare Advantage plans by $150 billion. Would I be correct in characterizing that as such?

Mr. {Holtz-Eakin.} The insurers will be increasingly caught in the middle. They have obligations to limit cost sharing. They have obligations to provide benefits. There will be less money coming to them. Their only recourse will be to restrict whatever access to benefits they already had and limit the network so as to control costs.

Dr. {Burgess.} So this is a story we are likely to hear repeated over time?

Mr. {Holtz-Eakin.} Yes. I think what we have heard so far is just the leading edge of what will be a bigger problem.

Dr. {Burgess.} So the American Association of Retired Persons has on its Web site myths about Medicare Advantage cuts, and one of the myths is that Medicare Advantage cuts would hurt seniors' ability to see their doctor. To quote the Web site: ``If your current plan allows you to see a physician in the plan, nothing will change.'' Well, in light of this information, do you think that that is an accurate statement?

Mr. {Holtz-Eakin.} No, I don't, and I think it will be increasingly inaccurate over time. To judge it by 2013 or

2014 is a mistake. It is the trajectory over the foreseeable future that concerns me the most.

Dr. {Burgess.} So, you know, again, I just can't escape the notion that the entirety of the Affordable Care Act was sold to the American people on deception. The consequences of that deception are not becoming more evident every day. As a physician, I am particularly sensitive to the fact that patients are going to be excluded from their doctors. I wish the Administration had been more honest about this, and again, I can't help but feel it was an active and purposeful deception.

Let me just ask you a question following up on some of the stuff that Chairman Dingell was asking. The cuts in Medicare Advantage, those cuts were taken out of Part A and Part B but not reinvested in Part A and Part B. Is that correct?

Mr. {Holtz-Eakin.} No, those cuts will be used to pay for Medicaid expansions and insurance subsidies in the exchanges, and those monies will be gone at the moment they are spent. They will not be there for Medicare.

Dr. {Burgess.} So I am not an economist. I am just a

simple country doctor. But you are an economist, so how do you reconcile the fact that they are claiming that that is a savings that is increasing the solvency and longevity of Part A and Part B when the money was taken and then spent for some other activity?

Mr. {Holtz-Eakin.} As the current CBO Director, Doug Elmendorf, has testified, and has any CBO Director would testify, that is an accounting fiction. There are no real resources in those trust funds to pay real bills from real providers for real patients.

Dr. {Burgess.} I thank the chair. I will yield back my time.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. {Castor.} Well, good morning, and welcome to the panel, and I would like to thank the chairman and ranking member for holding this hearing on how the Affordable Care Act is improving and strengthening Medicare and Medicare Advantage.

According to a study that was done a couple of months

ago, in my area of Florida, where we have a large percentage of our grandparents and parents who rely on Medicare, a number of statistics jumped out on the improved benefits in Medicare. One was what Mr. Dingell mentioned, the closing of the donut hole and the new discounts for prescription drugs. In the greater Tampa Bay area, over 77,000 of my neighbors now have major savings in their drug costs under Medicare Part D due to the drug discounts. They have been worth over $100 million to the Medicare beneficiaries in the greater Tampa Bay area. That is very substantial, and that is due to the Affordable Care Act.

Also due to the Affordable Care Act, just in the greater Tampa Bay area, over 100 million seniors now have Medicare coverage that includes preventive services. They can go get the mammograms, the colonoscopies without copays or deductibles. That is a very important improvement to Medicare.

And Mr. Baker, I think you testified that these improvements apply in traditional Medicare and in Medicare Advantage. Is that correct?

Mr. {Baker.} Yes, that is true. Yes, some Medicare

Advantage plans did offer those preventive benefits, others did not. So what the ACA did--and of course traditional Medicare did not. So what the ACA did was make sure that those preventive benefits applied across the board in both traditional Medicare and in all Medicare Advantage plans as well.

Ms. {Castor.} Well, and I would like to take a page of how Mr. Dingell asks questions sometimes because my time is limited and I would like to get a yes or no answer.

Earlier this year, Republicans here in the House adopted a budget that proposed drastic changes to Medicare. The budget that was adopted would end traditional Medicare and Medicare Advantage and put in place a new system beginning in 2024. So if you are 55 or younger, this would really impact your future in Medicare. Rather than enroll in traditional Medicare or Medicare Advantage under the Republican budget, instead beneficiaries would receive a voucher. It would privatize Medicare. You would get a voucher, a coupon, and most analysts raised grave concerns that this would in essence very shift costs to our parents and grandparents that rely on Medicare. It really appears to break the promise

that you will be able to live your retirement years in dignity and be safe from a catastrophic diagnosis.

I would like to know just yes or no from each of you, do you support that kind of drastic change to Medicare and Medicare Advantage? Yes or no.

Mr. {Holtz-Eakin.} I do support that change, and the reason I do is, the CBO's report that came out this summer indicated it would save costs for beneficiaries and for the government, indicating it had broken the increase in cost.

Ms. {Castor.} So, yes, you support turning Medicare into a voucher?

Mr. {Holtz-Eakin.} It bent the cost curve, and that is important.

Ms. {Castor.} And Mr. Baker?

Mr. {Baker.} I do not support that proposal, and our organization does not support the proposal for the reasons that you indicated, that it would not, the value of that voucher would not keep up with health care costs and so more would come out of pocket of seniors and they would lose the health security that they currently have.

Ms. {Castor.} Okay. Doctor?

Dr. {Margolis.} I believe it is important for Congress to assure health security for seniors. My apolitical answer, which is very hard to do here in Washington, I am sure, is to say this is about patients and patient care and that you should--

Ms. {Castor.} So yes or no? Turn Medicare into a voucher under the Republican budget?

Dr. {Margolis.} --support integrated care and coordinated care system development whether it is though that program or not.

Ms. {Castor.} Did you review the Republican budget proposal that privatizes--

Dr. {Margolis.} No, ma'am, I did not review it.

Ms. {Castor.} Okay. Ms. Gold?

Ms. {Gold.} We don't generally take positions on legislation. We let you guys do that. But there are a number of technical questions and issues that have been raised about those plans, about the cost shifting that would happen to Medicare beneficiaries that are important questions to answer before any change to a very popular program were made.

Ms. {Castor.} Okay. Mr. Kaplan, yes or no?

Mr. {Kaplan.} I believe that the idea of using a voucher-type system, which is very akin to what is being done in the Medicare Advantage space already, is a good idea.

Ms. {Castor.} Okay. That Republican Paul Ryan budget also included provisions to repeal the Affordable Care Act including the important reforms to Medicare--the closing of Medicare Part D coverage gap, known as the donut hole, the preventive services that we talked about earlier that are such a great benefit to many of my neighbors, those annual wellness exams, and important Medicare fraud prevention provisions.

Do you support the repeal of those provisions that have improved Medicare? We will start on this side. Mr. Kaplan, yes or no, because my time has run out.

Mr. {Kaplan.} I can't give a wholesale answer.

Ms. {Castor.} Just yes or no real quick, because my time has run out.

Mr. {Kaplan.} Yes or no. The answer--

Ms. {Castor.} You support repeal of those important reforms in Medicare that are included in the Republican

budget, or not?

Mr. {Kaplan.} I believe that are parts of ACA that should be repealed.

Ms. {Castor.} Ms. Gold?

Ms. {Gold.} I think beneficiaries would be pretty upset if they were repealed.

Ms. {Castor.} Doctor?

Dr. {Margolis.} I think protections for seniors are important.

Ms. {Castor.} Mr. Baker?

Mr. {Baker.} Those protections need to be continued and be in place.

Mr. {Holtz-Eakin.} I would answer differently, depending on the provision.

Ms. {Castor.} Thank you all very much.

Mr. {Pitts.} The chair thanks the gentlelady. The chair recognizes the gentleman, the chair emeritus from Texas, Mr. Barton, for 5 minutes for questions.

Mr. {Barton.} Mr. Chairman, I arrived late and didn't get to hear their testimony, so I don't have questions. I appreciate the opportunity, though.

Mr. {Pitts.} The chair now recognizes the gentlelady form Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. {Schakowsky.} I just wanted to make the point that I think Representative Castor was getting at too, just to remind my colleagues who are now complaining about cuts to Medicare in the Affordable Care Act, these were the same cuts that were included in the Ryan budget, but instead of strengthening Medicare, the Republicans wanted to give tax breaks to millionaires.

A couple of questions. The implication by my colleague, Dr. Burgess, was that changes that would eliminate and narrow networks are caused by the Affordable Care Act, and I am just wondering, Mr. Baker or Ms. Gold, in your research, I know with Part D it is important to check every year to make sure that the formulary is the same. With Medicare Advantage, aren't changes likely in the network or something prior to the Affordable Care Act as well?

Mr. {Baker.} Yes. I think there is a lot of volatility in this private marketplace, in this private Medicare Advantage marketplace, as well as in the Part D marketplace. So every year we are very clear with beneficiaries that if

they are in the Medicare Advantage plan, if they have a Part D plan, they need to check that coverage because the formularies, which are the list of covered drugs, change every year and provider networks change every year, and it is not just the plan that drives changes in provider networks; providers also decide to leave the network or to no longer be involved--

Ms. {Schakowsky.} So this is not new to--

Mr. {Baker.} No, this is an inherent part of the Medicare Advantage plan that has been around since the Medicare Plus Choice program in the mid-1980s and even before. So this is an ongoing issue. This kind of instability, if you will, is inherent and it is a part of the risks of the Medicare Advantage plan that go along with some of the benefits that we have talked about as well.

Ms. {Schakowsky.} Thank you.

Also, Ms. Gold, Mr. Holtz-Eakin said something about sort of the precarious future of Medicare and funding problems. I wonder if you could talk about the effect on solvency that the Affordable Care Act has had on Medicare. Do you have that?

Ms. {Gold.} I can try.

Ms. {Schakowsky.} Okay. Or maybe Mr. Baker would have more--

Ms. {Gold.} Yes, maybe. Go ahead.

Mr. {Baker.} I think we noted earlier that two effects have occurred. One is that, as I was responding to Mr. Dingell's comment, that there is a longer period of solvency of the Part A trust fund, and to the extent that that has been looked at through the years as a bellwether for the health of the Medicare program, we are in one of the best places we have ever been. And secondly, something that has inured to the benefit of all people with Medicare is a stable Part B premium. Medicare costs are at historically low growth rates right now.

Ms. {Schakowsky.} And that is what you had said too, Ms. Gold, right, that rates are down?

Mr. {Baker.} Right, and so everyone, all of the people with Medicare are seeing the benefits of that cost containment in the ACA and other cost containment efforts that have occurred both in private plans as well as in the government-run Medicare program.

Ms. {Schakowsky.} I also wanted to talk about low-income seniors. Medicare provides cost-sharing protections for low-income seniors through the Medicare Savings Program, or the MSP. I am wondering, if we are truly concerned about protections for low-income beneficiaries rather than paying more than Medicare to the Medicare Advantage plans, wouldn't it be better to invest additional resources in the Medicare Savings Program, improving outreach, enrollment and coverage, etc.?

Mr. {Baker.} The short answer to that is yes. I mean, we are very concerned. Our biggest problem on our help line is folks that can't afford their coverage, whether they are in the original Medicare program or in the Medicare Advantage program, and Medicare savings programs, as you say, are programs that help lower income above Medicaid income levels but lower-income folks. Fifty percent of people with Medicare have incomes under $22,500 a year, and many of them are struggling to afford coverage as well as dental work and other things that aren't covered by Medicare. So it is strengthening those Medicare savings programs or subsidy programs, particularly if we are looking at the SGR and doing

that simultaneously.

Ms. {Schakowsky.} Well, that I wanted to ask you about. We are certainly looking at the SGR. We would like to permanently repeal it, etc. But the qualified individual program which pays beneficiary Part B premiums is set to expire at the end of the year. So don't you think at the same time as we deal with the SGR, we ought to deal with that?

Mr. {Baker.} I think it is imperative that that program be continued and it be continued to be dealt with with the SGR and continued and reauthorized, yes.

Ms. {Schakowsky.} Thank you very much. I yield back.

Mr. {Pitts.} The chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. {Shimkus.} Thank you, Mr. Chairman.

Thanks for being here. Sorry I had to excuse myself during your testimony.

A couple points. One is, I, like myself, another member, a handful of staffers went down to make sure we were enrolled in our new health care plan because we couldn't get

confirmation. Fortunately, I got confirmation but I am finding out like everybody else is, I have less coverage at higher cost, and the real concern is, and exhibited by my constituents on Medicare Advantage, we are going to see the same thing occur in Medicare Advantage. And so I think this is really a timely hearing because it is just like everything else in this new movement of health care is, everybody is going to get less coverage and higher costs no matter who you are or where you are in this country because of these reforms.

I was here in committee when Secretary Sebelius I guess 2 years ago affirmed the fact that they double-counted the $500 billion. You can just check the transcript. You can check her testimony. It took me 5 minutes to get it out of her. But in the end, she said we have double-counted because we have this $500 billion of savings out of Medicare is going to go to Obamacare and of course, we are also strengthening Medicare by $500 billion. Having that as part of the record, how can we say Medicare is strengthened? Doug, can we make this argument that Medicare is now stronger than it ever has been?

Mr. {Holtz-Eakin.} I don't believe that the Part A trust fund reveals anything about the futures solvency of Medicare. The plain facts on the ground are that in recent years, the gap between premiums and payroll taxes going in and spending going out for the Medicare program as a whole is $300 billion. That is a gaping cash flow deficit. We get 10,000 new beneficiaries every day. In the absence of genuine reforms that allow people to continue to get the care they need and deserve and do it at a slower cost growth, this program will fall under its own financial weight.

Mr. {Shimkus.} You know, my point is, numbers really matter, and again, for the Secretary to affirm $500 billion that is really not chump change in the big picture of health care costs, I am getting comments from constituents in my district who Medicare Advantage folks now their benefits are being reduced, they are losing access to their preferred physicians. This is under the current system right now. Again, back to Doug, my question is, how much worse can this get for my seniors who opt for Medicare Advantage?

Mr. {Holtz-Eakin.} Again, if the strategy for controlling costs is this traditional one of just cutting

provider reimbursements, whether it is doctors, hospitals, MA plans, it will backfire. We have seen again and again that that approach without reforms, without an approach that gives you the prevention, the coordination and the better care, Congress ends up having to put the money back in because you haven't solved the problem, and to not put the money back in is to deny seniors care. That is your choice.

Mr. {Shimkus.} And Bob, a lot of my seniors through Medicare Advantage have access to dialysis and the like, and I know you have a special focus in that arena. As networks shrink, especially in rural America, what happens to our options? What could happen to our options?

Dr. {Margolis.} Well, I think you have heard that the cuts are not advisable in the future. I must say with all due respect to the committee, I think that the parity adjustment to get Medicare Advantage back to fee-for-service, which was enacted, is not the issue that should be focused on. What should be focused on, in my view, is that we are potentially reducing the payment for acuity of the sickest patients, which will incent insurers and others to avoid managing sick patients. Those are the ones that need

coordination, that need population health, that need the access to good care, and that that is the issue that I would hope the Committee will take a serious look at, because without that, while we may or may not have shrinking networks, and I think we will because even today we see news reports of United and others canceling thousands of doctors from the MA program, the real issue in my view as a physician and as someone who cares about seniors is that the sickest and most fragile patients that eat up all of the costs in health care are the ones that ought to be protected, and they ought to be protected by having appropriate acuity-adjusted payments to insurers or directly to the physician groups that are managing them in a way that supports better outcomes, transparency, performance measurement, all of the star measures are positive. Let us support quality, performance and outcomes, and pay accordingly based on managing our sickest seniors.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. {Green.} Thank you, Chairman Pitts and Ranking

Member Pallone for having this today, and our witnesses for taking the time to testify.

Medicare is critical to the well-being of our Nation's seniors and people with disabilities, many of whom have low to moderate incomes and complex health care needs.

My first question is, the Affordable Care Act did extend the life of Medicare by putting more money into Medicare, and I would like a yes or no answer to that. Did it actually extend the life of Medicare? And we will start with Mr. Holtz-Eakin.

Mr. {Holtz-Eakin.} No.

Mr. {Green.} It didn't?

Mr. {Holtz-Eakin.} No.

Mr. {Baker.} Yes.

Dr. {Margolis.} I have no knowledge of the facts.

Mr. {Green.} Thank you.

Ms. {Gold.} I don't study the trust fund.

Mr. {Green.} Okay.

Mr. {Kaplan.} Same for me. I have not studied the trust fund.

Mr. {Green.} Okay. Well, I think that we have many a

difference of opinion but I think that is acknowledged, that it did extend the life of Medicare with the Affordable Care Act.

Mr. Baker, in your testimony you discussed changes to Medicare Advantage under the Affordable Care Act. The ACA included policies designed to make the Medicare Advantage system more efficient, reduce overpayments to bring plans more in line with traditional Medicare and enhance plan quality. Can you elaborate on some of these improvements in managed care under the Affordable Care Act?

Mr. {Baker.} Well, as I said earlier, one of the improvements was making sure across the board that Medicare Advantage plans are covering preventive services as well as original Medicare. Another is the 85 percent Medical Loss Ratio so ensuring that 85 percent of every dollar, whether it is a consumer dollar or a government dollar, to these plans is going towards medical costs. Once again, the star ratings program and the out-of-pocket maximum, which I think have provided important financial protection to folks within the Medicare Advantage program, and the star ratings have made it easier, I think, for consumers to choose among plans. They

do have, as I said, many choices in most markets, and the problem we frequently see is folks not being able to choose among plans so the star ratings have helped that a bit.

Mr. {Green.} Well, and I know from my area, we have a really great Medicare Advantage plan with Casey Seabolt in Houston that actually quit taking general Medicare because they wanted all their patients to go in. Of course, they are a great facility.

What recommendations would you have to further improve Medicare Advantage?

Mr. {Baker.} Well, I think that once again we are very supportive of some of the good things that have come out of Medicare Advantage. We want to make sure that there are meaningful choices amongst plans, so really kind of standardizing plans to the extent that that is appropriate and possible. We would love to have more data on appeals within plans to see where there might be problems with a particular plan. We would like to make sure that there are better notices, so this issue that we have been talking about with regard to the slimming down of some of these networks, we do think that there could be more pinpointed notices sent

to consumers in the fall. Many consumers find out about this from their doctor. It would be nice if they found out about it from their plan in September when they get their annual notice of change so that they can be ready in the open enrollment period, which begins on October 15th.

And finally, I think we need to make sure that the original Medicare program continues to be a strong program and kind of a base program for folks, and by that, we could help by increasing the availability of Medi-gap policies and open enrolled Medi-gap policies so people can switch back and forth between the programs as necessary.

Mr. {Green.} We have heard that Medicare Advantage would lead to wide changes in ACA and Medicare Advantage would lead to widespread of the Medicare Advantage market. From your perspective, has this been the case?

Mr. {Baker.} We do not see widespread disruption at this point. We have seen some of these provider issues with providers leaving networks. Two things there: most of the consumers that have counseled have either chosen other plans that continue to have those providers in their network or have reverted to the original Medicare program where those

providers are available to them.

Mr. {Green.} Ms. Gold, you have researched and written extensively about Medicare and scientific studies must meet certain established standards for the findings to be accepted including transparency of data methods, peer review and confidence levels to establish the validity of the findings. As a professional researcher, I am interested to hear your thoughts on Mr. Kaplan's study which lacked, in my opinion, the standards. I believe there are many questions that we need to have answered before we can definitely say that his results have great meaning.

Ms. Gold, would you agree that these are some of the questions that one would want to have answered before accepting the validity of the conclusions and the results of Mr. Kaplan's study?

Ms. {Gold.} I do think, you know, usually when you have a study, they under peer review, the methods are laid out and you can look at it. I didn't have time to do a thorough review of the study but both I and a colleague looked at it quickly, and some of those details that you would want to see and which would ordinarily be there in a peer review paper

were not there.

I think the most major part of the study that wasn't really talked about in the testimony was the sort of finding that over one year, so many people live longer if they were in MA, and I don't think anyone really, whether they are pro or con MA or anything else, expects that that is a plausible finding. So I think there is some real questions about the risk adjustment and the selection of facts that are in that study. So, you know, I think there are some questions.

Mr. {Green.} I know I am out of time. Thank you, Mr. Chairman.

Mr. {Pitts.} Mr. Kaplan, do you want to take a moment to make a comment?

Mr. {Kaplan.} Yes. So I appreciate the comments, and thank you for the question. We did have our studies reviewed. We actually were surprised by the findings, and that really caused us to pause because we were so shocked by some of the data that the data showed. We didn't have an agenda walking into this. We wanted to figure out what it would show.

So we did have it reviewed by a number of organizations,

leading academic medical centers, because we wanted to challenge what we were saying. I understand that Ms. Gold did not review it or didn't have the time, and I respect that she didn't have the time to review it to be thorough, but we went through substantial reviews. What we said in this is that that one finding about mortality was the one that had greatest concern. That is why we wanted to go forward and do a longitudinal prospective study as opposed to just looking at it retrospectively.

But I would not throw out all the findings here. Again, we recognize that mortality was the one that is most concerning and no one wants to publish the fact that if you sign up for Medicare Advantage, you have a higher probability of living than if you sign up for Medicare fee-for-service. We did not want to publish that but it was a finding we found.

Ms. {Gold.} It wouldn't have been accepted in a journal because your detail wasn't there. I mean, I am not saying there may not be questions but the detail was not in the report to know whether in fact that was legitimate or not, and it wouldn't have gotten through peer review.

Mr. {Kaplan.} As I said, we did have it reviewed. We had it reviewed by leading academic medical centers. We did not submit it for peer review because we wanted to get it out to the market as quickly as possible.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes Dr. Gingrey 5 minutes for questions.

Dr. {Gingrey.} Mr. Chairman, thank you very much.

I will have to say that Mathematica Policy Research might sound a little more highbrow than Boston Consulting Group, but if any of you know anything about Boston Consulting Group, you know it is one of the most outstanding companies in this country, and I do know a little bit about that.

Ms. Gold, in your testimony, you suggested--I am paraphrasing a little bit but you suggested that the President fulfilled his promise to our seniors when he said if you like your health care plan, you can keep it, if you like your doctor, you can keep her. And you said it is called Medicare, suggesting, implying that if you got a notice from a Medicare Advantage plan that you had selected that you were no longer going to able to remain on the plan

or they are going to have to get out of the business because of the $14 billion cut, 14 percent cut per year over 10 years, something like $300 billion, it was okay because you still had Medicare. You just diverted back into Medicare fee-for-service. I would suggest to you that that is pretty disingenuous to say if you like your plan, you can keep it, because you get kicked out of Medicare Advantage and you can go to Medicare fee-for-service if you can find a doctor.

It is clear that the Medicare Advantage program is under attack and that these beneficiaries are beginning to feel the effects of the over $300 billion in direct and indirect cuts included in Obamacare, and with plan cancellation notices already sent to, what, tens of thousands of our country's seniors, some of the most vulnerable citizens are faced with this uncertainty that I just talked about. Individuals are losing coverage that they are happy with and the doctors with which they are comfortable, and this is a tragedy. It is a tragedy of the law, a bill that was rushed through Congress without any serious debate, strictly partisan vote, is now directly impacting people's lives and their personal health care decisions.

Mr. Holtz-Eakin, let me ask you, would you please explain to the committee the reality for those potentially millions of people, seniors who lose coverage over the next few years, especially when it comes to a reduction in financial security and benefits?

Mr. {Holtz-Eakin.} I think this is a very real possibility and something I am deeply concerned about, as you know. It is one thing to mandate that a Medicare Advantage plan cover certain benefits and offer those to seniors. It is another thing for that plan to be in existence so they can take advantage of it. And in the absence of a financial foundation, money trumps mandates. They won't have those choices, they won't have that care, and indeed, those who already have it, who made that choice, will see their plans taken away from them in violation of the promise.

Dr. {Gingrey.} Well, you know, the distinguished chairman emeritus Mr. Dingell--he is not still here, had to leave--but, you know, he made that statement in talking with Mr. Baker about the $14 billion that was saved out of the Medicare Advantage program, but of course, that $14 billion was not kept in Medicare, and really, he was only presenting

one side of the balance sheet. Yes, $14 billion may have been spent on Medicare Advantage. Whether that was a little too much is open to question. But the savings that occurred to Medicare and we the taxpayer because of this Medicare Advantage program that has preventive care and all these features that traditional Medicare fee-for-service does not have, certainly not care coordination.

This benefit is used by seniors from all walks of life. It is especially prevalent for the seniors, and I think you said this earlier, Mr. Holtz-Eakin, with lower incomes. These cuts to benefits and coverage will affect lower-income seniors more directly than others. Is that correct?

Mr. {Holtz-Eakin.} Yes, about 75 percent will be experienced by those making less than $32,000, ballpark.

Dr. {Gingrey.} And what will the loss of predictable annual cost mean to these populations?

Mr. {Holtz-Eakin.} These are the most vulnerable of the seniors, and this has been a program that has given them not just the services in traditional fee-for-service but additional services and done it in a fashion of coordinated care and high-quality outcomes. It is a loss of their

personal choice but it is a loss from the perspective of having a viable Medicare program for the future.

Dr. {Gingrey.} Thank you, Mr. Holtz-Eakin. I appreciate your leadership on this issue.

Seniors are just now learning that the upheaval of our health care is not limited to the individual insurance market. That is the purpose of this hearing today. They now know that it will affect them as well, and seniors may lose benefits. We have heard testimony from Mr. Holtz-Eakin, from Dr. Margolis, from Mr. Kaplan, seniors may lose benefits, they may lose access to doctors, and be forced to pay more for their coverage, plain and simple. And I yield back, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentlelady from Virgin Islands, Dr. Christensen, 5 minutes for questions.

Dr. {Christensen.} Thank you, Mr. Chairman, and welcome to our panelists this morning.

From what I have read overall, Medicare beneficiaries should expect, in response to the question that we are answering today, and are already experiencing improvements

from the Affordable Care Act, which have been enumerated by Chairman Dingell, my colleague, Ms. Castor, and others, and in part, those improvements, I think, have been made possible by the savings that came from equalizing the reimbursements of Medicare Advantage to those of traditional Medicare, and as a family physician and an old fee-for-service doc, I especially think that with the ACA reforms that the outcomes from both can be equally beneficial to the beneficiaries.

But I represent a territory, the U.S. Virgin Islands, and sometimes we have unique circumstances and suffer unintended consequences. So I want to ask a question on behalf of my colleague from Puerto Rico, and the question is to Bob Margolis. With the revised methodology under the ACA for paying Medicare Advantage plans using benchmarks based on fee-for-service data, should CMS coordinate the timing of the Medicare Advantage and fee-for-service processes? For example, in August of this year, CMS put out the 2014 fee-for-service inpatient rates that changed the Medicare disproportionate share payments to hospitals, but this was after the Medicare Advantage process for 2014 had closed in June, preventing the Medicare Advantage plans in Puerto Rico

from recovering the substantially increased DSH payments they must now make to hospitals. Shouldn't CMS address this lack of internal coordination for 2014 and its harm to Puerto Rico's Medicare Advantage plans and their beneficiaries?

Dr. {Margolis.} Thank you, Dr. Christensen. Clearly, I am not an expert on the rate setting but I would say that my understanding is that Medicare Advantage base rates are set based on the fee-for-service equivalency and that it makes very logical sense to me that we should have all of the built-in fee-for-service costs in the base rate when the Medicare Advantage rates are set. So I believe that would answer or direct an answer, and I think it is well known that CMS has for years not calculated the fact that SGR would probably be pushed out further so that they have not given credit to the SGR fix each year in setting the base rates for Medicare Advantage. So there are a variety of administrative issues I think related to how Medicare base rates are set.

Dr. {Christensen.} Thank you. I hope that answers Mr. Pierluisi's question.

Ms. Gold, I want to ask a question. We have heard a lot about the ACA causing spikes in premiums. While some plans

have increased costs on beneficiaries, isn't it true that overall average premiums paid by enrollees have declined since the Affordable Care Act was enacted? And could you elaborate a little more on the premium changes? Premiums are not the same across all plans. So what factors contribute to differences in premiums among plans?

So let me just add another part of this question because of time. Isn't it true that the more than 70 percent of beneficiaries who are in traditional Medicare are the ones subsidizing lower premiums for the people in Medicare Administrative?

Ms. {Gold.} Taking your second question first, yes, it is true that all beneficiaries subsidize it, plus the taxpayers, I might add, because that covers it too.

In terms of premiums, there is a lot of reasons. Costs vary a lot across the country, and some areas of the country are more efficient than others and some providers are more efficient than others. Premiums have often differed because fee-for-service payments are different. In some areas of the country, providers are stronger and they are able to negotiate higher rates. So there is less money available for

extra benefits. In some areas of the country, some plans decide to give it back in less cost sharing at point of service rather than lower the premiums. So there is a lot of reasons things differ.

And I should add, you know, this fight between doctors and health plans has a long history that goes back years, and it is attention. You are trying to get the most you can out of the system, and the best thing the policymakers can do, I think, and Congress is to set good standards and say we want to buy quality, we want to buy value, and to reinforce that. I think the stars do start to do that, and getting those rights and figuring out across both programs, both Medicare Advantage and Fred Fox, how to make care better for beneficiaries because I don't think that care is as good as it could be for Medicare beneficiaries no matter what you are in, and there is a lot of variation across plans in what they are doing, which is not even all their fault. A lot of it has to do with the providers in different areas and how willing they are to get together and how fragmented they are, and especially for beneficiaries who have chronic illness, they need providers who talk to each other, and that is hard

to change, and the plans are dealing with that and we are dealing with that because otherwise the beneficiary gets caught with the bill and the costs go up.

Mr. {Pitts.} The chair thanks the gentlelady and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questioning.

Dr. {Cassidy.} Yes. Thank you. I thought I was a ways after.

Ms. Gold, you sound like an advocate for MA plans because you are the one who is saying that there should be greater coordination of care.

And I am going to go to you, Dr. Margolis, because as a doc speaking to a doc, I thought your testimony was most kind of about what the patient's experience is as opposed to what the economists might say.

But Ms. Gold, just to point out, when you say that premiums will be lower in 2014 relative to 2010, that is because the market is actually offering lower-cost premiums with higher deductibles or allowing people to take their choice and therefore they are choosing a lower cost. It is not a function of the--that is what it is a function of.

Ms. {Gold.} No, I don't believe so. Partly, we don't have good data on the other kinds of cost sharing but I don't believe that there is evidence yet that that is why that has happened.

Dr. {Cassidy.} Common sense would suggest that. I will just say that. Because when people are voting with their pocketbook, they typically vote for a lower-cost plan.

Ms. {Gold.} Well--

Dr. {Cassidy.} And I am sorry, I have limited time.

Dr. Margolis, we have a controversy here. We have a controversy between Mr. Kaplan and Ms. Gold that says that they are not sure that there is improved quality data with MA plans. Your testimony is excellent. My gosh, when you show that graph of MA plans versus fee-for-service and the readmission rate is so much lower, number of hospital days, etc., that is just proof of what you are describing as an increased model of coordinated care. Fair statement?

Dr. {Margolis.} Well, thank you for that compliment, sir. I think that there are within the written testimony things that are very evident. First of all, I am a high promoter of transparency of quality results and payment

related to quality, so I recognize the star program as a very good step forward.

I wish there was a similar program in fee-for-service Medicare so we would have some evidence of whether Medicare fee-for-service is creating--

Dr. {Cassidy.} So let me emphasize, though, because I am a liver doctor, I take care of special needs patients like cirrhotics. You mentioned end-stage renal disease. That is where coordinated care is most important, and yet you describe the cuts that go to the special needs program, correct?

Dr. {Margolis.} Yes, I think I have said several times, I think the greatest threat at the moment is if we cut through this risk adjustment rescaling the benefit of adjusting payment based on acuity, we unfortunately then start to incentivize what used to be called cherry picking, which is avoiding high-cost patients. That is a disaster for seniors, and as you can see in the written testimony, if you really manage the high-cost seniors with comprehensive care, with palliative care, with end-of-life care with all those kinds of integrated programs, you can make a dramatic

reduction in utilization.

Dr. {Cassidy.} Dr. Margolis, I am going to cut you off a second because you have made your point, and I believe it. I have been struck that Ms. Gold and Mr. Baker continue to say they have not yet seen the problems that we are predicting and yet this wonderful graph in your testimony shows that we are just on the leading edge of these cuts and that there is compounding cuts that go through what you have in 2019 where there are dramatic cuts ultimately to MA plans will receive. Do I characterize your graph correctly?

Dr. {Margolis.} Yes, sir. It is why I have said that unfortunately--

Dr. {Cassidy.} Now, I am sorry, I just got a minute 30 left.

Now, you have been describing the dire things that could happen to these important programs like special needs plans based upon 2015, but if we just extrapolate that out, if we have Mr. Baker and Ms. Gold come back in 2019, at that point is it fair to say that more likely than not they will be able to say at this point we have seen a negative impact of the cumulative effect of these cuts upon patient care?

Dr. {Margolis.} I believe that is an accurate statement.

Dr. {Cassidy.} Yes, so do I. Just as a doc who is going to go home and talk to a woman who is losing her MA plan and she is a diabetic, and she has had this wraparound service that has been able to help her so tremendously.

Mr. Holtz-Eakin, can you just lay to rest this myth that the ACA actually prolonged the life of the Medicare trust fund?

Mr. {Holtz-Eakin.} As I said, there are no real resources in that trust fund. There is no way to pay a Medicare doctor's bill out of that trust fund. All the money that flows into it flows right out. The Treasury has spent every time of it and it is gone.

Dr. {Cassidy.} And so when Mr. Dingell or Mr. Green suggest that we have actually prolonged the life through the ACA and you flatly say no, with your credentials, you just totally dispute that?

Mr. {Holtz-Eakin.} I have testified numerous times as CBO Director and in the years since about the fiction of government trust funds actually being able to pay any bills,

and it is just a fiction.

Dr. {Cassidy.} I yield back. Thank you.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman, Mr. Sarbanes, for 5 minutes for questions.

Mr. {Sarbanes.} Thank you, Mr. Chairman. I appreciate the testimony of the panel.

Congressman Gingrey said something earlier, which I wanted to respond to. He said that seniors are now learning that the ACA is going to cause them harm. I don't think seniors are learning that. I think seniors are being told that by fear-mongering members of the other party who don't like the ACA, and I think that if seniors look carefully at their experience over the last couple of years, a period in which the positive impact of the ACA has begun to be felt, they will conclude that in fact the ACA is benefiting them. You look at the closing of the donut hole, you look at the new coverage of certain kinds of preventive care services, screening and other care services, annual wellness visits where copayments have been eliminated, you look at the incentive structures that have been put in place to help

improve management of care and chronic conditions in a more sensible way within the traditional Medicare fee-for-service context as well as obviously within the MA context, there is just item after item of improvements which are there because of the Affordable Care Act, which are making the Medicare plan and Medicare coverage more robust for our seniors. So it is just wrong to suggest that this is going to be harmful to the senior population.

In a sense, this hearing is titled ``What beneficiaries should expect under the President's health care plan, Medicare Advantage,'' and I think they can expect good things. Everybody here generally is saying good things about the Medicare Advantage program. That is not the dispute we have. It is whether the Affordable Care Act is having a negative impact on what 29 percent of Medicare beneficiaries have access to or a positive impact. So when Mr. Baker and Ms. Gold say good things about the Medicare Advantage program, which they have, that is not somehow a contradiction on the other statements and testimony they are offering here. I think it is very consistent. It is just that you believe, in contrast to the other witnesses here, that the Affordable

Care Act is actually strengthening and improving Medicare Advantage.

My understanding, Mr. Baker, is that the premium that was offered initially to Medicare Advantage plans, which is, I think, 114 percent against what the fee-for-service rate is, was done because the government wanted to incentivize the market and the private health insurance industry to come in and innovate and was successful in doing that. If you have 29 percent of beneficiaries that are now in those plans, it shows that that has happened. But along the way, because of good, rigorous analysis, we discovered that that premium was no longer justified, and in fact was going to some things that really ended up being a waste from the standpoint of the Medicare program. Can you just speak--I have used up most of my time here--but can you just talk again about two or three of the things that you think the Affordable Care Act has done to improve the Medicare Advantage program, which I think all of us want to see remain strong?

Mr. {Baker.} I think, you know, three main things. One is the Medical Loss Ratio making sure most of the money that goes to--85 percent goes to medical care. I think, two,

closure of the donut hole and the addition of preventive care services. I would also add, and I haven't talked about this before, but the Affordable Care Act does set up a program to enhance coordinated care in the fee-for-service traditional Medicare program through accountable care organizations and through other mechanisms as well as, I think, strengthen Medicare Advantage-like programs in many States that are partnering with the Federal Government with regard to coordinated care for dual eligibles, people eligible for both Medicaid and Medicare, and that is an ACA-generated program that does have some promise. It needs to be monitored but it looks like it has some promise.

Mr. {Sarbanes.} Thank you.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. {Griffith.} Thank you very much, Mr. Chairman.

I want to highlight a real-life example. My 83-year-old mother reports that her rates have risen for Medicare Advantage plan. In order for her to keep the policy that she has and likes, she is now paying higher rates. When

Secretary Sebelius was here in April, she claimed Medicare Advantage rates were decreasing nationwide. So I did a survey in my district, and we found that more had rates going up, not a huge amount. As Mr. Baker testified, the biggest group, or a bigger group, was those who stayed about the same. There were a couple of folks who reported that their rates had gone down.

I am just wondering, Mr. Holtz-Eakin, is this the case from your perspective nationwide that the Medicare Advantage rates are going down, as Secretary Sebelius testified earlier this year?

Mr. {Holtz-Eakin.} We can get back to you with the data but I don't think those are the facts, but I would emphasize that there are big differences across counties, regions, States in the United States.

Mr. {Griffith.} And let me go to that point because I had some curiosity as to whether that was one of the reasons was that I represent a very rural district where it takes hours sometimes to get to the nearest hospital, depending on where you are located, particularly since as a result of Obamacare and the cuts to Medicare we lost a hospital in one

of my most rural counties a few months back. That was two of their top three reasons for why they were closing the hospital. Do you find that that is more likely to be a problem in rural areas where the rates are going up as opposed to more urban areas?

Mr. {Holtz-Eakin.} Well, it is much harder to, you know, narrow networks, which is one of the ways to control costs in a rural setting because you don't have many choices, so they don't have the option to do that.

Mr. {Griffith.} Yes, and in that particular county, they had one choice and now they have to drive a fairly--depending on what part of the county you live in, a fairly good distance to get to the next choice where they also only have one choice depending on what direction they go in. I do appreciate that.

Dr. Margolis, I ask you a rural question to in that you were talking about the health care and Dr. Cassidy, who I respect very much, showed the chart from your testimony and how the cuts are coming, and you indicated earlier in your testimony that is going to limit access for some folks. Is that going to be far more worse in the rural districts like

mine?

Dr. {Margolis.} I think that it is predictable that cuts will affect rural areas where there are fewer choices rather than the urban areas where there is more competition but I can't say that I have evidence to support that.

Mr. {Griffith.} But common sense would lead us to that conclusion, would it not?

Dr. {Margolis.} Yes.

Mr. {Griffith.} Ms. Gold, do you want to disagree?

Ms. {Gold.} Yes, because the ACA has the lowest payment counties actually benefiting. In some of the rural counties, they are going to continue to have 115 percent of fee-for-service. So I don't think it is payment in rural areas. I agree, there is a lot of problems in rural areas with managed care and getting it set up but I don't think it is the payment changes per se that are causing the problem.

Mr. {Griffith.} So you would disagree with the folks who just had to close the hospital in Lee County, Virginia, and you would tell them that were mistaken in looking at their numbers?

Ms. {Gold.} No, I can say that they have a real problem

but it is not the ACA.

Mr. {Griffith.} Well, unfortunately, those were two of the three things that they listed as the problem. The other one was the war in coal, in essence, the downgrading of the economy in our region also responsible to this Administration.

But the other two things they listed were the ACA and the cuts to Medicare, so two out of the top three have hurt my people, and obviously I am very concerned about it and now I think it is going to affect perhaps the elderly also disproportionately represented in the rural areas of my district.

Mr. Holtz-Eakin, in that regard, you indicated that we shouldn't be looking at these Medicare Advantage rates based on 2013 but we should be looking to the future. Can you explain that more fully?

Mr. {Holtz-Eakin.} Well, I am concerned that the current experience has been amassed, as the chair mentioned at the outset, by the demonstration program, the Medicare stars demonstration program, which I will just take this opportunity to say not all MA plans are uniformly wonderful.

It is a good idea to have a stars program to rate them. The demonstration program is not a good program. It does not reward good performance, and it needs to be reformed so that it actually does. But they plowed $8 billion in and disguised the genuine financial future of Medicare Advantage for the near term.

Mr. {Griffith.} And I appreciate that.

And Mr. Chairman, with that, I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. {Engel.} Thank you, Mr. Chairman, and thank you, Mr. Pallone, for having this hearing today.

You know, I have been listening to my Republican colleagues lamenting the fact that health care costs, they say, are going up. They claim that the ACA is causing this to happen, although it is not true, and yet when we identify savings and cost, then they conversely say how terrible it. Well, you really just can't have it both ways.

In 2009, prior to the passage of the ACA, the rates paid to Medicare Advantage plans exceeded that of traditional

Medicare by about 18 percent and the ACA required changes to Medicare Advantage payment rates to better align them with the costs associated with traditional Medicare, and these changes were estimated by the Congressional Budget office to save over $135 billion over 10 years. So you just really can't have it both ways. Every time we identify a way to save money, my colleagues on the other side of the aisle say look, this is so terrible, this is being cut, that is being cut, and then they claim that the ACA is causing costs to rise. I mean, you just can't have it both ways.

According to the 2010 Medicare Payment Advisory Commission report to Congress that in 2009 Medicare spent about $14 billion more to beneficiaries enrolled in the Medicare Advantage plans than it would have spent if they had stayed in traditional Medicare. So I want to go along the lines of the questions that Mr. Sarbanes did, and ask Ms. Gold, how did we get to the point where we were paying so much for private insurers through Medicare Advantage to provide Medicare benefits and isn't it accurate that reforms in the ACA will help correct the overpayment problem with Medicare Advantage plans and play a role in extending

Medicare solvency for all beneficiaries?

Ms. {Gold.} Yes, I think it will have that effect.

Mr. {Engel.} I think it is also worth noting that all of the cuts to Medicare that were included in the ACA were also included in each of the Republican budget proposals for the last three years. So under Republican proposals, these cuts to Medicare Advantage will continue too.

On trust fund solvency, I want to mention the way we measure this solvency is by the Medicare trustees' report, and the trustees' report shows post-ACA solvency of Medicare is extended, and I think that is important to state as well.

Mr. Baker, I know that in the past there have been concerns about Medicare Advantage plans cherry picking and seeking to enroll the healthiest of seniors, leaving sicker beneficiaries enrolled in traditional Medicare. Have you seen evidence of this practice continuing, or what steps did the ACA take to try to stop this practice?

Mr. {Baker.} Well, once again, I think the provisions in the ACA that require Medicare Advantage plans to have similar cost sharing for benefits that are typically used by sicker beneficiaries, and by that I mean renal dialysis,

skilled nursing facility care and chemotherapy is one of the ways that those plans have become more attractive to those sicker beneficiaries and are something the plans can't use to kind of cherry-pick healthier beneficiaries over sicker beneficiaries.

I think what we see anecdotally, and it is borne out by some of the research, is that folks typically do join Medicare Advantage at a relatively younger and healthier age. As they age and become more chronically or severely ill, some do disenroll and enroll in traditional Medicare thinking that certain treatments, certain providers are more available in the original Medicare program. And so we do see that pattern emerge anecdotally in our work.

Mr. {Engel.} Thank you, Mr. Baker. Let me ask you this question on a different subject. In New York, we have about 2,100 physicians eliminated from United Health's Medicare Advantage provider network and is expected to impact about 8,000 of New York seniors. This was a business decision made by a private company and CMS is prohibited by law--I think it is important to say that--from interfering in the payment arrangements between private health insurance plans and

health care providers. But I do hope that CMS will use the authority it has to ensure adequate provider networks are in place for all Medicare Advantage plans to help ensure beneficiaries have access to health care services.

So let me ask you, for seniors whose physicians are no longer a part of a specific Medicare Advantage network, what suggestions would you offer them? My understanding is that more than 90 percent of physicians in America are willing to accept new patients under the traditional Medicare program so is moving to traditional Medicare an option for them right now?

Mr. {Baker.} Moving back to the original Medicare is an option for them right now or moving to another Medicare Advantage plan. It is our understanding that most of those physicians and most of the hospitals or other providers that have been dropped from United or other Medicare Advantage networks are in other Medicare Advantage networks or are, as you said, in the original Medicare program. So this happens every year to some extent and so our advice is consistently the same this year: look for another plan that has your provider in it or return to the original Medicare program if

that is a better program for you overall and your provider is also involved in that program.

Mr. {Engel.} Thank you. Thank you, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. {Bilirakis.} Thank you, Mr. Chairman, and thank you for holding this very important hearing. Thank you, panel, for your testimony as well.

Mr. Kaplan, I was reviewing your report about how Medicare Advantage provides better outcomes and greater savings than traditional Medicare. Why does capitated MA produce such dramatically better results?

Mr. {Kaplan.} I think there are probably two or maybe three things to take away that I think drive that, so one is the alignment of incentives, so in a capitated world, I think we all understand that the incentives are aligned between those who pay for the health care and those who provide the health care. So with that alignment, things tend to be more productive in how they perform.

The second point is that because of that alignment, what

happens is that there is a huge investment in preventive care, so when they have the same goals and they are working towards the same, they are going to try to avoid these acute interventions to fix something that has gone dramatically wrong so they work with the member or the patient to try to manage them through it.

And the third point I really want to emphasize, which is what Dr. Margolis said, which is the issue around many of these members become very sick with time, age as well as where they are socioeconomically, and when they are, of the sickest portion or the 5 percent that drives 52 percent of the costs that require even greater intervention and greater coordination and so when these ideas of coordinating care and aligning incentives are very important, in all aspects of health care, it is extremely important towards the more chronically sick individuals.

Mr. {Bilirakis.} Thank you very much.

Mr. Holtz-Eakin, in the last Congress, about 40 percent of the seniors in my district had Medicare Advantage plans. So they love their plans, and it is very popular in my area. Of course, again, they like their plans. Back in 2010, CMS's

Chief Actuary did a report on the impact of Obamacare to Medicare Advantage. He wrote, and I quote, ``We estimate that in 2017''--I know you touched on this, but elaborate, please--``We estimate that in 2017 when the MA provisions will be fully phased in, enrollment in Medicare Advantage plans will be lower by about 50 percent.'' Does this track with your own analysis of these cuts?

Mr. {Holtz-Eakin.} Absolutely. As you have heard today, Medicare Advantage is a high-quality program. It is very popular. In your district, it is even more popular than nationwide. The senior population is rising, 10,000 new beneficiaries every day. One would expect that if nothing else changed, you would see more enrollment, a lot more enrollment; we are going to see less. What has changed is the financial foundation. The cuts under MA are going to make it impossible for plans to survive, and those that survive will have to change their networks and their benefits and their cost sharing in ways that seniors will find undesirable. The net result is going to be less availability of Medicare Advantage.

Mr. {Bilirakis.} Thank you. Next question for you,

sir. Some Democrats have been pushing the accountable care organizations--ACOs--as a model for better care coordination and better cost savings. Doesn't Medicare Advantage promote the same concept with a proven track record of better outcomes and cost containment?

Mr. {Holtz-Eakin.} MA has a track record, and it is by and large a high-quality track record, as I said earlier. Not every MA plan is created equal but it has a track record. ACOs are a concept at this point and unproven, and there is one big difference: seniors choose their MA plan, seniors are assigned to their ACO, and they have no choice, and that is the significant difference in the two concepts.

Mr. {Bilirakis.} Thank you very much. I yield back, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you to our panel for being here on this issue.

Surveying the 2nd District of North Carolina, I have been hearing in the--you know, since the rollout of Obamacare

that my constituents who are losing their Medicare Advantage are very, very concerned about this issue, as you can imagine, and it is showing in North Carolina that the cuts to benefits for seniors for Medicare Advantage are over $2,000 per beneficiary. Now that we are seeing this play out, the things that I am hearing from my constituents are that they are losing their access to care to their physicians, the cost is going up, and again, as you can imagine, they are very, very concerned about this issue.

To Mr. Holtz-Eakin, who again is going to be most affected by these Medicare Advantage cuts? Which sector of population of our seniors? Because I keep hearing over and over again that it is helping our chronically ill patients who have this coverage and this is a better plan for them. Is that not who we are harming?

Mr. {Holtz-Eakin.} This is a better plan for those with multiple chronic diseases in particular that need carefully coordinated care. They are typically lower income. There are typically more minority participants in MA. That is the population that will be affected, no question about it.

Mrs. {Ellmers.} Now, what are some of the--can you

identify some of the actual tangible benefits? I know you talked about coordination of care and items like that. Are there any more specifics that we can hear so that we all have a better understanding of what we are actually losing?

Mr. {Holtz-Eakin.} I will cede to the greater wisdom of Dr. Margolis and let him go first.

Mrs. {Ellmers.} Dr. Margolis, would you--and I actually have another question for you, Dr. Margolis, on that issue. You know, you had identified quite correctly that we really need to be talking about taking care of those patients who are at the end of life, the ones who--you know, we know those are where the dollars are really being spent. How do you feel about the IPAP, Independent Payment Advisory Board? That is going to come into play there, don't you believe?

Dr. {Margolis.} Yes, ma'am, I certainly do not think that organizations like that should make decisions about individual patient care, on the one hand. And let me just say relative to that very sensitive topic: almost nobody wants to die in a hospital--

Mrs. {Ellmers.} Thank you.

Dr. {Margolis.} --if they have support at home, and

with coordinated care, integrated programs, spiritual counseling, palliative care, pain management and 24-hour access to caregivers, you can avoid almost everybody having that unfortunate event in their family. That is a big opportunity, and let us support special needs programs, the dually eligible, and move towards Medicare Advantage much more aggressively.

Mrs. {Ellmers.} I appreciate those comments, and that is exactly why I am as concerned about this issue as you are.

And Ms. Gold, I just have to ask you, yes or no, isn't that what you identified a few moments ago when you said that you thought coordination of care could be better served under another plan and under Affordable Care Act that that actually happens?

Ms. {Gold.} I think there is a lot of problems with getting coordinated care.

Mrs. {Ellmers.} But doesn't Medicare Advantage actually do that?

Ms. {Gold.} No, only some plans do it. It has the potential--

Mrs. {Ellmers.} No, I didn't--

Ms. {Gold.} --but it doesn't have the reality--

Mrs. {Ellmers.} Clarification here. I did not say that every Medicare Advantage plan but I did say that Medicare Advantage plans offer these benefits. Is that yes or no?

Ms. {Gold.} Yes.

Mrs. {Ellmers.} Thank you. And just to finish out, we have got about a minute, and this question is actually to Mr. Holtz-Eakin and to Mr. Kaplan.

You know, we have heard the bipartisan concerns here, and you know, we want to make sure that we take care of our seniors, but we can see over and over again the Affordable Care Act is so negatively affecting our seniors with their Medicare Advantage plans. Just coming from a completely bipartisan perspective, what can we do now moving forward? What would you like to see in Medicare Advantage that we can move to that we can actually make a difference? Because we are going to have to make changes in Medicare, yes, and I would like to know from both of you what your thoughts are on what we need to do in Medicare so that we can make it better for our seniors.

Mr. {Holtz-Eakin.} Well, I think it is very important

that we have a sustainable social safety net for our seniors. Medicare needs to be a different program in the future both financially and because the care that seniors need is different than when Medicare was founded. Medicare Advantage is a great steppingstone to that future. It is not the end but it is a great steppingstone. It needs to be preserved, not wither on the vine in the next 5 years.

Mrs. {Ellmers.} But we need that financial backing.

Mr. {Holtz-Eakin.} And the near-term thing would be this risk adjustment issue that Dr. Margolis has mentioned. That is a very serious concern in terms of the funding.

Mrs. {Ellmers.} Wonderful. And Mr. Kaplan, very quickly, if you can add to that.

Mr. {Kaplan.} My simple answer is that this public-private partnership has been very successful and therefore, in my mind, we should invest in that and make that better as opposed to cutting it back.

Mrs. {Ellmers.} Thank you so much. Thank you to all of you, and thank you to the chairman. I went over my time, so thank you for allowing me to do so.

Mr. {Pitts.} The chair thanks the gentlelady. That

concludes our first round of questions. We will go to one follow-up per side, and Dr. Burgess will begin with 5 minutes of follow-up.

Dr. {Burgess.} Dr. Holtz-Eakin, I just want to follow up on some stuff we were talking about earlier in the first round. It appears in Washington today there is a crisis in confidence. The President has sold the Affordable Care Act on just a raft of false promises. You can keep your plan--false. You can keep your doctor--false. These are broken promises and these in fact are the opportunity costs that Americans are paying for the Affordable Care Act.

There was a promise made to seniors as well. The promise was that we are going to use your Medicare dollars as a piggy bank to fund the Affordable Care Act, and in doing that, we will improve Medicare and allow seniors to keep their doctors if they liked. So do you have an opinion as to whether or not this is yet another broken promise?

Mr. {Holtz-Eakin.} It is.

Dr. {Burgess.} And is it fixable?

Mr. {Holtz-Eakin.} It is fixable in Medicare Advantage. I don't believe fee-for-service Medicare is fixable, it is

the problem, so the focus should be on fixing Medicare Advantage in the ways that we described earlier, and--

Dr. {Burgess.} But--

Mr. {Holtz-Eakin.} --promises are just that: they are promises. They are, you know, if you like your individual policy, you can keep it, but the regulations and the funding are at odds with the promise. The promise can't be held true.

Dr. {Burgess.} So fixing it would involve alteration in the funding?

Mr. {Holtz-Eakin.} Absolutely.

Dr. {Burgess.} And at present, do you see any way or any mechanism by which that could happen? Is there anything to give you optimism that that funding in fact could be restored?

Mr. {Holtz-Eakin.} Under current law, it won't happen. We need to change.

Dr. {Burgess.} Let me ask you this. I wasn't here in 1988 and 1989. I don't know if you were involved.

Mr. {Holtz-Eakin.} I am old, yes.

Dr. {Burgess.} But there was a--Dan Rostenkowski, the

Democrat chairman of the Ways and Mean Committee, put forward a catastrophic care program. He was very proud of it. It passed the Congress, a bipartisan vote, as I recall. They went home all very satisfied with what they had done. And then something odd happened. People rejected the law that was passed, and they rejected it largely because in a similar way, it sort of moving funding around in a way that seniors thought would be deleterious to their well-being. So then do you remember what happened the spring after that?

Mr. {Holtz-Eakin.} After they got the bill and after they chased him with the umbrellas, they repealed the law.

Dr. {Burgess.} So there is a mechanism by which this problem could be fixed also if we follow the 1989 repeal as precedent?

Mr. {Holtz-Eakin.} There is no question this is fixable. It requires the Congress to act and the President to sign.

Dr. {Burgess.} And it may require the people with umbrellas chasing the chairman of the Ways and Means Committee down the street.

Mr. {Holtz-Eakin.} No comment.

Dr. {Burgess.} No comment.

You know, I do have to just address the issue or ask, I mean, here we have all these experts in front of us. We get reports that the cost in Medicare has come down. In fact, we are going to get by the end of this week, I think the Congressional Budget Office is going to give us a projection on the proposed cut in the Sustainable Growth Rate formula, which is likely to be less than what everyone was anticipating. So that is good news. It may improve the score for repealing it.

A lot of opinions out there as to why this cost reduction is occurring. Of course, the Administration in USA Today 2 weeks ago wanted to take credit for it and say it is all the Affordable Care Act. I don't know that is has really had time. Certainly the recession is playing a role but I don't know if that is the entirety of it. We are here just literally just 10 years passed the signing of the Medicare Modernization Act with the provision of Medicare Advantage and the Medicare prescription drug benefit, and if we really do believe that it is better to a stitch in time saves nine and it is better to treat early before a disease gets well

established, perhaps we are seeing some benefit from passing the Medicare Modernization Act. Do any of you have an opinion as to whether or not that may be playing a role in these lowered costs? Yes, sir.

Mr. {Holtz-Eakin.} I don't know how much of the current slowdown in health spending growth we can attribute to prescription drug therapies but we know the CBO and others have found that the Part D program has reduced costs elsewhere in Medicare, and that has been an important part of the change in the cost structure of Medicare. It has also been an important part of the structure of the entitlement. The Part D program which will have its 10th anniversary on Sunday is probably our most successful entitlement, and we should try to model every reform we can as closely to that as possible.

Dr. {Burgess.} And that was actually constructed to be more like insurance and less like entitlement, if I recall those discussions back in the midst of time 10 years ago.

I thank everyone on the panel. It has been very informative. I know it has been a long morning, and Mr. Chairman, I will yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the ranking member, Mr. Pallone, 5 minutes for follow-up.

Mr. {Pallone.} Thank you, Mr. Chairman.

I just wanted to say--I am going to ask my question of Mr. Baker but I just wanted to say with regard to Mr. Holtz-Eakin's testimony with regard to ACOs, I just disagree. You know, with ACOs and traditional Medicare, seniors have the ultimate choice. I mean, they can see any provider they want. They are not locked in for a year like they are with an MA plan. That is just my opinion. When I heard you talk about ACOs, I just wanted to express my view, which is that they are not locked in. They can choose whoever they want with ACOs in a traditional Medicare plan.

Mr. Baker, I just wanted to ask you about how Medicare Advantage can be improved. I think all of us here today agree that the Medicare Advantage program is a crucial alternative to traditional Medicare, especially for individuals with complex health care needs. But in your opinion, based on your organization's work over the years in assisting Medicare beneficiaries, what recommendations do you

have for how the Medicare Advantage program could be improved for beneficiaries?

Mr. {Baker.} Of course. I mean, I think the promise of managed care when it was initially put forward in the 1980s and then mid-1990s, a big push was that it would actually save the Federal Government money and provide coordinated care and additional benefits to people with Medicare. I think we have talked a lot about the advantages of Medicare Advantage but some of that promise hasn't been met. As we have talked, some of the plans are better than others but overall the level of coordinated care does vary widely amongst plans. And so we think, you know, better monitoring and oversight by the Centers for Medicare and Medicaid Services to make sure that those promises are kept, once again, better information about appeals within those programs. We oversample for the complainers in my organization. People call us when they have problems, and consistently what we see in the Medicare Advantage plans are problems with access to care, with utilization management or other barriers put to a variety of care, and we work with physicians and the plans to ease those barriers for people

with Medicare and Medicare Advantage.

So having that information publicly available about which plans and how they are really kind of setting up maybe unnecessary barriers to care would be helpful and enable people to not only compare benefits but also to compare how those benefits are administered by particular plans and making sure that people are choosing those plans that actually are fulfilling the promise that a lot of us have talked about with regard to coordinated care, and I think, you know, once again, this idea of custom tailoring stars, if you will, the stars program, while it is good, needs to be better and that people really want to know when you are looking at your two cars in Consumer Reports, there is not only stars on the cars overall but also on engine performance and on brake performance and other kinds of performance measures. So we will get to a place where I think we can customize those stars even more, and that will also help folks choose between the programs.

I want to reiterate that I think the original Medicare program or the traditional Medicare, which we have had since 1965, is the bedrock. It is something that people

continually know is there and go back to, and it has, you know, regardless of a lot of what we have said, if you look at over the last 30 years, Medicare, the traditional Medicare program, and private insurance have done about the same job curtailing costs, good or bad. And so I think there is a lot of improvement that can be made in the original Medicare but there is also a lot of improvement that could be made in Medicare Advantage as well.

Mr. {Pallone.} I only have a minute left, but some people including you have suggested we should consider establishing a so-called Medicare Part E, which would supplement original Medicare without beneficiaries having to pay for the overhead and profits of private insurance plans, and it intrigues me. Could you just elaborate a little on how you would envision that would be structured or how it would be an improvement to the current Medicare structure? You have a minute.

Mr. {Baker.} In a whole minute? I think the Commonwealth Fund and others have put together a more comprehensive proposal on what is called Part E Medicare, and basically what it would do is combine Part A, Part B, Part D,

prescription drug and Medi-gap, Medicare supplemental, in a government-run program, and this would go toe to toe with Medicare Advantage and with the original Medicare program as it exists now. Once again, it is an alternative. It is something that would exist alongside, and it would allow more choice for consumers and could have a lot of these coordinated benefits and coordinated coverage that we have been talking about today.

So I think that it is something that I think would put together in one place government-run program that has all of these components that people with Medicare value and need and could save money.

Mr. {Pallone.} Thank you so much. Thank you, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman. The chair thanks all the witnesses for your testimony. This has been an excellent hearing, very informational.

The members may have follow-up questions. We will submit those to you in writing. We ask that you please respond promptly. I remind members that they have 10 business days to submit questions for the record, so they

should submit their questions by the close of business on Wednesday, December 18.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:26 p.m., the subcommittee was adjourned.]